ACHIEVE! CENTER, INC.

ACHIEVE CENTER (Child)

Client____ DOB______________
(first) (MI) (last)

Gender ☐ Male ☐ Female Ethnicity: ______________________________

Mailing address______________________ City__________ State______ Zip ______

Telephone Home______________ Work______________ Cell______________

May we contact you at home? ☐ yes ☐ no At work? ☐ yes ☐ no On your cell? ☐ yes ☐ no

Person financially responsible________________ **Social Security Number**__________

Relationship to client______________________ Home phone______________

Address______________________ City__________ State______ Zip______

Parent (mother)________________________________ DOB__________

Mother's Social Security Number______________________________

Address______________________ City__________ State______ Zip______

Employer______________________ Business Phone______________

Mother's Phone Number______________________

Mother's Email Address ______________________________

Parent (father)________________________________ DOB__________

Father's Social Security Number______________________________

Address______________________ City__________ State______ Zip______

Employer______________________ Business Phone______________

Father's Phone Number ______________________

Father's Email Address ______________________________

Who is legally responsible for child?______________________________

With whom does the child reside?______________________________

Referral Source______________________________

Emergency Contact______________________ Phone______________

Primary Care Physician and Clinic______________________________

INSURANCE INFORMATION

Primary Insurance Name______________________________

Policyholder Name______________________ Policyholder DOB______________

Member ID Number______________ Group #__________ Insurance Phone #______________

Secondary Insurance Name______________________________

Policyholder Name______________________ Policyholder DOB______________

Member ID Number______________ Group #__________ Insurance Phone #______________

We ask for your social security number only because it is required by insurance providers

©2020 Achieve Center

ACHIEVE! CENTER, INC.

CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

Important

Failure to answer all questions may result in the delay of appointment scheduling.
If a question does not apply, write N/A. If you do not know the answer, write DO NOT KNOW.
Note: The information you provide is confidential and protected by law.

Date: _______________

Demographic Information

Child's name:______________________________ Date of Birth: ________ Age: ________Gender: ☐ Male ☐ Female

Who referred you:____

Why are you requesting services for you child? ____

____

What concerns bring you here?

Behavior Problems:

☐ Self-injurious behavior ☐ Lying/stealing ☐ Struggles socializing ☐ Clingy ☐ Rage
☐ Physical aggression ☐ Refusal to attend school ☐ Withdrawn ☐ Tearful ☐ Nightmares
☐ Verbal aggression ☐ Alcohol/drug use ☐ Other behavior of concern:______________________________

Emotional Distress:

☐ Depression/sadness ☐ Moodiness ☐ Suicidality/homicidality ☐ Death
☐ Anger ☐ Anxiety ☐ Psychotic-like symptoms ☐ Parents divorce
☐ Other:____

Functional Problems:

☐ Poor hygiene ☐ Physical pain/injury ☐ High or low energy ☐ Concentration problems
☐ Problems with mobility ☐ Impulse control ☐ Poor grades ☐ Poor organization skills
☐ Problems with Hearing ☐ Social relationships ☐ Memory problems ☐ Unmotivated
☐ Problems with speech ☐ Sleep problem ☐ Learning problems ☐ Lack of coordination
☐ Recognition of danger ☐ Eating problem ☐ Cognitive problems ☐ Fine Motor problems
☐ Money management ☐ Sensory problems ☐ Problems with play ☐ Feeding Aversion
☐ Safety problems ☐ Employment ☐ Problems with getting along with others ☐ Difficulty chewing/swallowing (coughing, choking) retaining food in mouth
☐ Irresponsible

DEVELOPMENTAL HISTORY

Mother's age at time of the child's birth: __________ **Father's age at time of the child's birth:** __________

Was your child possible exposed to alcohol, nicotine or other substances during mother's pregnancy? ☐ Yes ☐ No

What were the complications or concerns during the pregnancy for the mother? ☐ None
(If any of the following occurred, please elaborate on condition/treatment.)

☐ Gestational diabetes ☐ Anemia ☐ Preeclampsia ☐ Placenta previa ☐ Toxemia ☐ Depression
☐ Sexually transmitted disease ☐ Heart disease ☐ Physical trauma ☐Premature labor ☐ Abuse
☐ Other: _______________ ☐ Prescribed medications: ______________________________________

Was bed rest required? ☐ No ☐ Yes
If yes, please describe timeframe and reason:____

Length of Pregnancy

☐ Full term ☐ Premature – born at how many weeks? _____ Birth weight ______

Place of Birth ☐Hospital name ____ ☐ home ☐other

Was labor induced? ☐ No ☐ Yes, please describe the reason:____________________________________

Length of labor _________________ **Length of time pushing** ___________________

Mode of delivery: ☐ Vaginal ☐ Cesarean ☐ Emergency Cesarean
How many days was the baby in the hospital? _______________

Were there any concerns or complications during/immediately following your delivery?

☐ Baby's heart rate dropped
☐ Born "blue"
☐ Low Apgar scores of _______
☐ Difficulty sucking
☐ Treatment in the NICU – details: ____________________
☐ Cord wrapped around neck/umbilical cord
☐ Breech
☐ Significant jaundice (bilirubin)
☐ Low blood sugar
☐ IV fluids
☐ Oxygen
☐ General concerns about the baby's overall physical appearance

Temperament as an infant: ☐ Easy ☐ Withdrawn ☐ Difficult to calm ☐ Other: ____________

Bonding: ☐ Cuddly ☐ Withdrawn ☐ Clingy ☐ Other: ____________

Activity level as an infant: ☐ Average ☐ On-the-go ☐ Destructive ☐ Lethargic ☐ Accident prone

Apprehension with strangers: ☐ Mild ☐ Moderate ☐ Severe ☐ None

Emotionally oversensitive/over-reactive as an infant: ☐ No ☐ Yes
Does this continue to be a problem? ☐ No ☐ Yes

Developmental milestones (check all that apply):

By 2-4 Weeks:
☐ Can sleep for 3 or 4 hours at a time
☐ Responds to parent face/voice
☐ Searches for parent's face
☐ On stomach, lifts head momentarily
☐ Can stay awake for >1 hour
☐ When crying, can be consoled most of the time, by being spoken to or held

By 2 Months:
☐ Coos/vocalizes
☐ Smiles responsively
☐ Lifts head, neck, and upper chest w/support of forearms from stomach

By 9 Months:
☐ Responds to name
☐ Understands a few words
☐ Babbles
☐ Reaches for objects
☐ Crawls, creeps, or scoots
☐ Sits unsupported
☐ Plays peek-a-boo or pat-a-cake
☐ Pokes with fingers, shakes, bangs, throws, drops objects
☐ Feeds self with fingers

By 12 Months:
☐ Pulls to stand and may take a few steps alone
☐ Drinks from cup
☐ Says 2-4 words, imitates vocalizations
☐ Looks for dropped or hidden objects
☐ Steps while holding on
☐ Waves "bye-bye"
☐ Feeds self
☐ Brings toys/object to show

By 18 Months:
☐ Walks backward
☐ Throws ball
☐ Scribbles
☐ Uses two-word phrases
☐ Uses a spoon and cup
☐ Shows affection, kisses
☐ Follows simple directions
☐ Points to some body parts
☐ Pulls a toy along the ground
☐ Watches face for reaction

By 24 Months:
☐ Goes up and down stairs one step at a time
☐ Kicks ball
☐ Stacks five blocks
☐ Uses at least 20 words, two-word phrases
☐ Follows two-step commands
☐ Imitates adults

By 5 Years:
☐ Dresses self without help
☐ Learns address/phone number
☐ Can count on fingers
☐ Copies basic shapes
☐ Recognizes most letters and prints some
☐ Speech is easily understood

By 11-18 Years:
☐ Sexual development and behaviors
☐ Peer relationships
☐ Worries about grades
☐ Social/emotional interaction

Toilet trained? ☐ Yes ☐ No (circle all that apply): Daytime wetting Nighttime wetting Bowel incontinence

Puberty: ☐ No ☐ Yes, started at age: _______ If female, first menstruation age: _____

Cares for self: ☐ Yes ☐ No ☐ With help (i.e. Bathing, Dressing, Grooming) Comment: ____________________

MEDICAL HISTORY

Date of last physical examination: ______________ **Name of Physician:** ______________________________
Purpose of physical examination:____

____

Name of primary care physician & clinic name: ______________________________________

☐ **Major Surgery** (attach additional information/list if needed):

Procedure: ______________________________ Procedure: ______________________________

Age: __________ Age: __________
☐ No complications ☐ No complications
Complications:______________________ Complications: ______________________

☐ **Medical Hospitalization** (attach additional information/list if needed):

Cause: ______________________________ Cause: ______________________________

Dates/Age: ______________________________ Dates/Age: ______________________________

☐ **Medical Diagnoses:**

1.	3.	5.
2.	4.	6.

Has the child ever experienced the following? If yes, please elaborate below.

☐ High fever requiring hospitalization or treatment: ______________________________
☐ Unexplained fever or spike of temperature: ______________________________
☐ Head injury: ______________________________
☐ Concussion: ______________________________
☐ Loss of consciousness: ______________________________
☐ Seizures Type: ☐ Partial ☐ Partial complex ☐ Generalized
Beginning at what age: ______________ Frequency: ______________________________
☐ Tics or abnormal body movements: ______________________________
☐ Thyroid or endocrine problems
☐ Chronic ear/sinus infections Were tubes required? ☐ No ☐ Yes, at what age(s): ______________
☐ Strep throat ☐ Diabetes/blood sugar problems ☐ Meningitis, encephalitis
☐ Bronchitis, pneumonia ☐ Upper respiratory problems/asthma
☐ Other congenital conditions: ______________________________
☐ Lead or other toxin exposure: ______________________________

Please list currently prescribed medications:

	Medication	Dose	Frequency	Prescribing Physician
1.				
2.				
3.				
4.				
5.				

Past medications that have produced a negative reaction/ineffective medications:

	Medication	Dates used	Reason for Discontinuation
1.			
2.			
3.			
4.			
5.			

Current Medical Conditions/Illnesses

Hearing: ☐ No problems ☐ Conductive impairment ☐ Sensory-neural impairment ☐ Hearing devices
Vision: ☐ No problem ☐ Nearsighted ☐ Farsighted ☐ Glasses ☐ Contacts ☐ Blind ☐ Other:____________
Speech: ☐ No problem ☐ Does not speak ☐Speaks words, no sentences ☐ Words difficult to understand ☐ Stutters

Current Sleep

☐ Duration in hours: _____ ☐ Requires naps ☐ Midnight awakening ☐ Early awakening
☐ Difficulty falling asleep ☐ Other: ______
☐ Nightmares ☐ Frequency: _______ per week ☐ Content: ______
How handled: ______

Eating

☐ No problems ☐ Obsessed with food – since: ________ ☐ Increased/decreased appetite – since: ______
☐ Weight gain/loss Amount in pounds: __________ Since: ______
☐ Drooling ☐ Food falls from mouth ☐Gags ☐ Eats limited types of food ☐ Has taste/texture sensitivities
☐ How handled: ______

Allergies: ☐ No ☐ Yes **Diagnosed by:** ______

Describe: ______

How Treated: ______

Swallowing Problems: ☐ yes ☐ no
Describe: ______

How Handled: ______

Special Diet: ☐ yes ☐ no
Describe: ______

MOTOR SKILLS:
Please describe your child's gross motor skills (e.g. running, jumping, catching a ball, etc.): ______

______

______

Please describe your child's fine motor skills (e.g. holding a crayon, holding a spoon, staying in line when coloring, etc): ______

______

Speech/Language:

Verbal Skills:
Is your child verbal?: ☐ Yes ☐ No
If verbal, at what age did your child begin using: 1 words? ____________ sentences? __________

Delay in verbal response: ☐ Yes ☐ No

Describe: ______

Becomes frustrated with self-expression: ☐ Yes ☐ No

Describe: ______

Uses speech/language assistance devices: ☐ Yes ☐ No

Describe: ______

Verbal Skills:
Can use words to express needs/wants: ☐ Yes ☐ No

Describe: ______

Can pronounce words correctly: ☐ Yes ☐ No

Describe: ______

SKILLS AND ABILITIES:
Any concerns with:

Reading ☐ Yes ☐ No
Describe:____

Writing ☐ Yes ☐ No
Describe:____

Math ☐ Yes ☐ No
Describe: ____

Knows colors: ☐ Yes ☐ No ☐ All ☐ Some
Which colors if some known?: ____

Knows letters: ☐ Yes ☐ No ☐ All ☐ Some
Which letters?: ____

Knows numbers: ☐ Yes ☐ No ☐ All ☐ Some
Which numbers?: ____

Can count: ☐ Yes ☐ No
How high?: ____

Knows shapes: ☐ Yes ☐ No
Which shapes?:____

Can identify objects: ☐ Yes ☐ No
Which objects?: ____

Can point to objects: ☐ Yes ☐ No
Which objects?: ____

Can imitate others verbalizations: ☐ Yes ☐ No
Which Verbalizations?: ____

Can imitate other actions: ☐ Yes ☐ No
Which actions?: ____

Can do puzzles: ☐ Yes ☐ No
How big of puzzles?: ____

Can add: ☐ Yes ☐ No

Can subtract: ☐ Yes ☐ No

Can multiply/divide: ☐ Yes ☐ No

Has advanced math skills: ☐ Yes ☐ No
Describe: ____

Has computer skills: ☐ Yes ☐ No
Describe: ____

Reads: ☐ Yes ☐ No
Describe: ____
Subject preferred: ____

Spells: ☐ Yes ☐ No ☐ Has difficulty Describe: ____

Writes: ☐ Yes ☐ No
Describe how holds pencil: ____________________
Describe aides if used: ____________________
Describe penmanship: ____________________

Has the child been diagnosed previously with any type of developmental diagnosis?

☐ ADHD/ADD Date of diagnosis: __________ Type: __________ By Whom: __________

☐ Autistic spectrum disorder (autism, Asperger's syndrome, PDD.NOS) Circle one
Date of diagnosis: __________ By whom: __________

☐ Cognitive impairment (mild / moderate / severe) Circle one
Date of diagnosis: __________ By whom: __________

☐ Receptive / expressive / mixed speech delay Circle one
Date of diagnosis: __________ By whom: __________

☐ Learning Disability
Date of diagnosis: __________ Type: __________ By Whom: __________

☐ Mental health diagnosis:
Date of diagnosis: __________ Diagnosis: __________ By Whom: __________

☐ General development delay
Date of diagnosis: __________ By Whom: __________

Allied health professional(s)

	Name	Time Frame/Dates of Treatment
Speech/Language		
Occupational Therapy:		
Physical Therapy:		
Other:		

Past mental health professional(s)?

	Name	Time Frame/Dates of Treatment
Psychologist(s):		
Psychiatrist(s):		
Neurologist(s):		
Other:		
Inpatient Treatment:		

Current mental health professional(s)?

	Name	Time Frame/Dates of Treatment
Psychologist(s):		
Psychiatrist(s):		
Neurologist(s):		
Other:		

Ever had psychological or neuropsychological testing? ☐ Yes ☐ No
By whom? __________ When? __________

Does your child have any of the following behaviors?
Aggression towards property: ☐ Yes ☐ No

Describe: ____________________

Triggers: ____________________

Frequency: ____________________

Reduction strategies: ____________________

Aggression behaviors toward self: ☐ Yes ☐ No

Describe:________________________________

Triggers:________________________________

Frequency:________________________________

Reduction strategies:____________________________

Aggression towards others: ☐ Yes ☐ No

Describe:________________________________

Triggers:________________________________

Frequency:________________________________

Reduction strategies:____________________________

Self stimulation: ☐ Yes ☐ No

Describe:________________________________

Triggers:________________________________

Frequency:________________________________

Reduction strategies:____________________________

Avoidance: ☐ Yes ☐ No

Describe:________________________________

Triggers:________________________________

Frequency:________________________________

Reduction strategies:____________________________

Obsessions/compulsions: ☐ Yes ☐ No

Describe:________________________________

Diversion Technique:____________________________

Meltdowns: ☐ Yes ☐ No

Describe:________________________________

Triggers:________________________________

Reduction strategies____________________________

Sensory:

Please describe any known or suspected sensory issues - sensitivities:________________

____

SUBSTANCE ABUSE

Please indicate any substance used currently or in the past by the child or parent:

Current	Past		child	mother	father
☐	☐	Alcohol	☐	☐	☐
☐	☐	Marijuana	☐	☐	☐
☐	☐	Ecstasy	☐	☐	☐
☐	☐	Huffing (gas, aerosol, etc.)	☐	☐	☐
☐	☐	Other: ____________			

Has the child ever attended a substance abuse treatment program? ☐ No ☐ Yes

FAMILY

Current Living Situation

☐ Biological parents (married or cohabitating)
☐ Biological parents (divorced/separated) ☐ with visitation ☐ without visitation
☐ Biological mother and stepfather/parent partner ☐ with visitation ☐ without visitation
☐ Biological father and stepmother/parent partner ☐ with visitation ☐ without visitation
☐ Foster or adoptive family
☐ Other: ______________________________

Placement/Visitation Schedule: ______________________________

Name of mother: ______________ DOB: ________ Employer: ______________ Position: ______________

Name of father ______________ DOB:________ Employer:______________ Position: ______________

Date of marriage:______________ Date of divorce (if applicable): ______________

Mother's highest education level:______________ Father's highest education level: ______________

Name of stepmother: ______________ DOB: ________ Occupation: ______________

Name of stepfather:______________ DOB: ________ Occupation: ______________

Names of siblings	Living in the home	DOB	Quality of Relationship
____________	Y N	________	☐ Good ☐ Fair ☐ Poor
____________	Y N	________	☐ Good ☐ Fair ☐ Poor
____________	Y N	________	☐ Good ☐ Fair ☐ Poor
____________	Y N	________	☐ Good ☐ Fair ☐ Poor
____________	Y N	________	☐ Good ☐ Fair ☐ Poor

Names of stepsiblings	Living in the home	DOB	Quality of Relationship	From mother's Marriage (check)	From father's marriage (check)
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐

Other important persons in the child's life:

Name	Age	Nature of Relationship to Child	Quality of Relationship
____________	______	______________	☐ Good ☐ Fair ☐ Poor
____________	______	______________	☐ Good ☐ Fair ☐ Poor
____________	______	______________	☐ Good ☐ Fair ☐ Poor
____________	______	______________	☐ Good ☐ Fair ☐ Poor

FAMILY HISTORY QUESTIONS

Does anyone on either the mothers side or fathers side of the family have had or are suspected to have had difficulties with any of the following: (please check which side of family)

	Mother's Side	Father's Side
Attention	Who: ________	________
Learning Difficulties	Who: ________	________
School Problems	Who: ________	________
Behavior Problems	Who: ________	________
Depression	Who: ________	________
Anxiety	Who: ________	________
PTSD	Who: ________	________
Drug/Alcohol abuse	Who: ________	________
Legal issue	Who: ________	________
Hallucinations/delusions	Who: ________	________
Bipolar/depression	Who: ________	________
Eating	Who: ________	________
Epilepsy	Who: ________	________
Mental Retardation	Who: ________	________
Dementia, Alzheimers	Who: ________	________
Traumatic Brain Injury	Who: ________	________
Autism, Aspergers	Who: ________	________
Heart or lung problems	Who: ________	________
Speech/Language problems	Who: ________	________
Genetic Disorders	Who: ________	________

Significant Trauma (include age at time of incident, nature of trauma, and any legal details)

☐ Injured in an accident: ________

☐ Physical abuse (child was the ☐ victim ☐ perpetrator): ________

☐ Sexual assault/abuse (child was the ☐ victim ☐ perpetrator): ________

☐ Emotional abuse (child was the ☐ victim ☐ perpetrator): ________

☐ Neglect: ________

☐ Removed from home ☐ Foster care ☐Residential treatment ☐ Parent or other removed from home

SOCIAL RELATIONSHIPS

What words best describe the child?

☐ Friendly	☐ Withdrawn	☐ Shy
☐ Popular	☐ Socially awkward	☐ Few friends
☐ Leader	☐ Socially "clueless"	☐ No friends
☐ Used to have more friends	☐ Interested in friends	☐ Not interested in friends

How did the child adjust to the social demands of preschool/kindergarten (e.g., group activities, sharing, playing with other children, etc.)**?** ________

Losses/separations (deaths, moves, etc.): ________

Extracurricular activities/religious participation: ________

DISCIPLINE

Physical: ☐ Spanking ☐ Other: ________

Non-physical: ☐ Time outs ☐ Yelling/screaming ☐ Taking things away ☐ Praise

☐ Other: ________

Child's response to discipline: ________

PERSONAL INFORMATION
What are the child's greatest strengths/attributes? ______________________________

____

Hobbies/Interests/Activities they enjoy doing

Recent change in frequency?

______________________	☐ No change	☐ Decreased	☐ Increased
______________________	☐ No change	☐ Decreased	☐ Increased
______________________	☐ No change	☐ Decreased	☐ Increased
______________________	☐ No change	☐ Decreased	☐ Increased

LEGAL
Please detail any contacts the child has had with the courts, police, etc.: ______________________________

____

____

EMPLOYMENT ☐ No employment history due to age
Was the child ever employed? ☐ Yes ☐ No
Was the child successful at job? ☐ Yes ☐ No – details: ______________________________
Was the child ever fired? ☐ No ☐ Yes – details: ______________________________
Jobs held: ______________________________
Household chores: ______________________________

ACADEMIC
Current school: ______________________________ **Current grade:** ______________
Started school at age: _____
Participated in: ☐ Title I reading ☐ Developmental kindergarten ☐ Early childhood education ☐ Birth to 3

Has the child utilized Special Education support services? ☐ No ☐ Yes ☐ IEP ☐ 504 Plan
Please specify below all classifications that have been used, and *circle any current classification.*
☐ Cognitively impaired ☐ Emotionally impaired ☐ Hearing impaired ☐ Visually impaired
☐ Other health impairment ☐ Severe multiple impairment ☐ Speech and language impairment
☐ Learning disabled: ______________________________

Academic Performance:
☐ Consistently above average (A's, B's) ☐ Consistently average (B's, C's)
☐ Consistently below average (C's, D's) ☐ Consistently below average to failing (C's, D's)
☐ Previously strong grades, recent deterioration ☐ Previously weak grades, recent improvement
☐ Dropped out of school (at age: _____, grade: ___________)
☐ Graduated from high school ☐ Obtained GED ☐ Regular diploma ☐ Special education certificate

Was child ever:
☐ Held back – What grades? ______________________________
☐ Suspended – For what and for how long? ______________________________
☐ Expelled – From what grade and why? ______________________________
☐ Home schooled – When and why? ______________________________

Additional information you would like to let the clinician know (state your primary concerns regarding your child):

____

____

____

Completed by
Parent/Guardian: ______________________________ **Date:** ______________

Therapist: ______________________________ **Date:** ______________