

Dr. Kenny Handelman's Intake Form

Name: _____ Date: _____
Preferred Nickname: _____ Gender: M F Age: _____
Birth date: _____ Home #: _____
Daytime contact: _____ Evening contact: _____
Family Doctor: _____ Pediatrician: _____

Address: _____
City: _____ Prov: _____ Postal: _____

Information supplied by: _____

Main Concern(s):

Child's Demographics

Birthplace: _____ Ethnic identification _____

School: _____ Year in school _____

Is there a modified program at school? Yes No

If "yes", please explain: _____

Child's current residence: With biological parents Other: _____

If "other," please explain: _____

Parents' Demographics

Father's name: _____ Birth date: _____

Biological parent? No Yes

Address: _____

City: _____ State: _____ Zip code: _____

Employer: _____

City: _____ Telephone number: _____

Occupation: _____ Shift: _____

Mother's name: _____ Birth date: _____

Biological parent? No Yes

Address: _____

City: _____ State: _____ Zip code: _____

Employer: _____

City: _____ Telephone number: _____

Occupation: _____ Shift: _____

Alternate Contacts

Emergency contact: _____

Telephone number: _____ Relationship: _____

Family and Home Information

All persons currently living in the household:

Name	Birth date	Sex	Education level	Relationship
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____

Natural parents or siblings who do not live in the household:

Name	Birth date	Sex	Education level	Relationship
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____

Child's Developmental and Medical History

Were there any prenatal problems during pregnancy? No Yes

If "yes," please explain: _____

Were there any problems during delivery? No Yes

If "yes," please explain: _____

Birth weight: _____ lbs _____ oz.

Infancy:

A. Were there any feeding problems? ___ No ___ Yes
If "yes," please explain: _____

B. Did your child sleep well? ___ No ___ Yes
If "no," please explain: _____

C. At what age was your child toilet trained? _____
Were there any difficulties? _____

Milestones

At what age did your child:

_____ Wean _____ Walk _____ Sit up alone _____ Talk
Were there any difficulties? _____

Are there any problems with bedwetting/accidents? ___ No ___ Yes
_____ Night _____ Frequency
_____ Daytime accidents _____ Frequency

Please indicate age of child at the time of illness:

_____ Chickenpox _____ Mumps
_____ Diphtheria _____ German measles
_____ Red measles _____ Poliomyelitis
_____ Rheumatic fever _____ Scarlet fever
_____ Tuberculosis _____ Whooping cough
_____ Pneumonia _____ Other

If "other," please explain: _____

Does or did your child ever have severe ear infections? ___ No
_____ Yes

Does or did your child have allergies? _____ No
_____ Yes

If "yes," to what does the child have allergies? _____

How severe are the reactions? _____

Are there any special precautions that need to be taken? _____

Has your child ever had a head injury? ___ No ___ Yes

If "yes," please explain: _____

Has your child ever had a seizure? _____ No ___ Yes

If "yes," please explain: _____

Has your child ever had surgery? _____ No ___ Yes

If "yes," please explain: _____

Please detail any of your child's hospitalizations:

Date	Age	Hospital	Reason	Length of stay
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please detail any medication history (use back if necessary):

Date	Age	Drug	Reason	Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family Medical History

Is there a history of any of the following in the family?

(Use "M" for mother's side; "F" for father's side.)

_____	TB	_____	Vision problems
_____	Birth defects	_____	Hearing problems
_____	Emotional problems	_____	Drugs
_____	Behavior problems	_____	Alcohol
_____	Mental retardation	_____	Diabetes
_____	Goiter (Thyroid)	_____	Convulsions/seizures
_____	Depression	_____	Anxiety
_____	'Nervous Breakdowns'	_____	Bipolar Disorder
_____	Manic Depression	_____	Schizophrenia
_____	ADHD	_____	Learning Problems
_____	Criminal Behaviour		
_____	Other		

If "other," please explain: _____

Further comments: _____

Agency Involvement/Service Treatment History

Please include (chronologically if possible) as complete a history as possible. Include agencies, physicians, counselors, institutions, therapists, etc.

Date	Age	Contact person	Services provided	Length of involvement
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has your child been court involved? No Yes

If "yes," please explain: _____

Child's School History

Have there been problems at any academic level? Please detail here. Please give any information about treatment (if any) provided by the school at the time of occurrence:

Discipline

What methods do you use to discipline your child? _____

How often is it necessary? _____

Does it work? _____

Do parents agree on the approach? _____

Are parents consistent with the discipline? _____

Please describe other problems: _____

What behavior distresses you the most? _____

What do you think are your child's greatest strengths? _____

Please describe the changes you hope to see in your child as a result of your session with Dr. Handelman:
