Intake Form Children (1~ 19 years old)

Please fill out the following information in as much detail as possible. This will help us to gain a better understanding on your first intake meeting.

Date:_____

Name of child (Name used regularly in home country)	_____ First _____ Middle _____ Last	Gender:
Name of child (as indicated on insurance forms)	（カタカナ: ）	Nationality:
Date of Birth		Age:
Languages Spoken		
School and grade		
Address	〒 -	
Phone number	Home ( ) Cell Phone ( )	

Family Background

Name of father		Occupation:
Date of birth		Nationality:
Phone number		
E-mail address		Spoken languages:

Name of mother		Occupation:
Date of birth		Nationality:
Phone number		
Email address		Spoken languages:

Other family members or people living together

Name	Age	Relation with child	School/Occupation	Physical or mental health related issues

Past history and reason for consultation

Please describe the presenting issues and anything else you would like to discuss at the clinic.

Has the child ever been seen by a psychiatrist or psychologist/counselor? Please list.

Name of Clinic/Hospital	Outpatient /Inpatient	Date	Diagnosis/Treatment

Has the child ever had any psychological or neuropsychological evaluations? Please list.

Organization/Clinic	Type of evaluation	Date

∗ *If you have a copy of the evaluation report, please present it with this form.*

Developmental History

About pregnancy
Age of the mother during pregnancy: _____
Any complications or problems during pregnancy? If so, please describe:

About birth
Type of birth: _____
Gestation weeks: _____
Apgar score: _____

Developmental milestones

Milestone	*Age in months*	*Milestone*	*Age in months*
Lift own head		Walk without help	
Turn over		Pointing	
Sit without help		First word	
Crawl		What was the first word?:	
Stand with help		Use of two-word sentences	
Stand without help		Shyness with new people	

Has anything been pointed out by the child's pediatrician in previous screenings?

Health History

Has the child ever been seriously ill or hospitalized in the past? If yes, please describe.
Has the child been evaluated in the following areas? If so, please describe. ①Vision Test（Date:　　）Results: ②Hearing Test（Date:　　）Results: ③EEG　（Date:　　）Results:
Does the child have any allergies? If yes, please describe:
Does the child have any issues with eating? (E.g. picky eater, eating too much or too little, etc.)
Does the child have any issues sleeping? (Sleeping too much or too little, night terrors, etc.) Sleep time（　　:　　）～ Wake up time（　　:　　）
Is the child currently taking any medication? If so, please describe:

Name of medication	*Dosage*	*Starting date*

Social Interests

Hobbies and interests:
Social relationships Number of friends:　　Age range of the friends:
How is the child's interaction and play with friends?
Is the child participating in extracurricular activities? If yes, describe.

Educational History

Name of school	Place/ Country	Years in school	Age	Language of instruction	Special support?

Are there any specific issues regarding school life? (Grades, bullying, attention issues, etc.)

_____
_____
_____
_____
_____
_____

Is there anything that requires special consideration during the consultation or something you would like to add? If yes, please describe

_____
_____
_____
_____

Are there any specific services that you are seeking?

☐ Counseling/ Consultation/ Early Intervention _____

☐ Psychological assessment_____

☐ Medication or other medical services _____

How did you get to know about this clinic?
Website / Referral from other institutions/ clinics / Recommendations from friends/ family
(Name of institution or person who referred the clinic: _____)

Thank you for taking the time to fill out this intake form!

Name: _____

Relation with the child: _____

Date:_____