# 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 (as indicated on insurance forms)** | （カタカナ：　　） | Gender:<br>Nationality: |
| Date of Birth | | Age: |
| Languages Spoken | | |
| School and grade | | |
| Address | 〒　　- | |
| Phone number | Home (　　)<br>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 | | |
| E-ail 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.)<br><br>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*<br>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

_____

_____

_____

How did you get to know about this clinic?

Website / Referral from other institutions/ clinics / Recommendations from friends/ family

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

Name: _____

Relation with the child: _____

Date : _____