EARLY CHILDHOOD *Wellness place*

520 Zang Street Suite 212; Broomfield, CO 80021 (303) 460-3881

Client Clinical Intake Form

Birth History Biological Mother's age at time of client's birth: _____years

Biological Father's age at time of client's birth: _____years

Did Biological Mother smoke while pregnant? ___YES___NO Drink Alcohol? ___YES___NO Use Illicit Drugs? ___YES___NO

Did Biological Mother take medications during pregnancy?___YES___NO Please list:_____

Was Biological Mother under a doctor's care during pregnancy? ___YES___NO

Pregnancy History: Any complications or major stressors during pregnancy? _____

About the delivery: Number of weeks_____ Vaginal_____ Cesarean _____Other Complications_____

Was the baby in the hospital or NICU for more than 2 days? ____YES____NO

If YES, please explain:_____

Developmental History As closely as you can remember, please indicate when your child…

Was your child breastfed?____YES____NO If YES, for how long? _____ Any difficulty breastfeeding?____YES____NO

If YES, describe: _____

Age of Walking _____ Age of Talking _____

Did your child seem clumsier than other children? ____YES____NO If YES, describe_____

Any concerns about fine or gross motor skills? ____YES____NO If YES, describe_____

Age when toilet trained consistently:_____ Please list any difficulties in toilet training:_____

Temperament As an infant/toddler did your child establish the following routines normally…

Sleep / Wake Cycle ____YES ____NO Eating ____YES____NO Was your child interested in other people?____YES____NO

Did your child have colic? ____YES____NO

Was your child overly sensitive to:

- Particular sounds (sirens, loud noises)? _____YES ____NO
- Particular sensations (tags on clothes, socks, light touch, movement such as swinging)? _____YES ____NO
- Particular Smells? _____YES ____NO
- Particular Tastes/Textures? _____YES ____NO

Was your child:

- Slow to warm up? _____YES ____NO
- Shy? _____YES ____NO
- Overactive? _____YES ____NO
- Underactive? _____YES ____NO
- Aggressive? _____YES ____NO

Previous Mental Health Treatment History

Date(s)	Provider Name/Facility	Purpose

Religious / Spiritual Identity

Medication History

Is the client currently taking prescription medications? ( ) Yes ( ) No If YES, please list names and dosages:
Is the client currently taking non-prescription medications? ( ) Yes ( ) No If YES, please list names and dosages:
Allergies? ( ) Yes ( ) No

Review of client's Physical Symptoms:

YES	NO	Check one for each symptom	YES	NO	Check one for each symptom
		Frequent or severe headaches			Low blood pressure
		Dizziness or fainting spells			Recent loss / gain weight (circle one)
		Eye / Vision Problems			Diabetes
		Head injury			Epilepsy or seizures
		Thyroid trouble			Jaundice or liver disease
		Asthma or shortness of breath			Fatigue/Lack of Energy
		Hearing Problems			Previous Hospitalization
Additional details:					

Family Medical History

Issue	Client	Bio-Mother	Bio-Father	Siblings	Grandparents	Other Relatives
ADHD						
Learning Issues						
Alcohol/Drug Abuse						
Anxiety						
Depression						
Bipolar						
Schizophrenia						

Parent/Guardian Printed Name:_____

Parent/Guardian Signature:_____Date:_____