ADDSOI
Testing Center

The ADD SOI Testing Center
2007 Cedar Ave Manhattan Beach, CA 90266
310-546-8583 fax 310-546-9068 www.ADDSOI.com

Child Intake Questionnaire

Child's Information

Child's Name: ______________________ Person Completing Form: ______________________

Child's DOB: ______________ Was Child Adopted?: ____________ Today's Date: ______________

School:______________________ Grade: ______ Wears Glasses: ______________

Medication currently taking: ________________ Referred by: ______________________

Parent email______________________

Mother/Guardian Information

Name: ______________________ DOB: ______ Occupation: ______________________

Home Address: ______________________ Primary Phone #: ______________________

______________________ Alternate Phone #: ______________________

______________________ ` ______ May I leave messages? ______________________

Father/Guardian Information

Name: ______________________ DOB: ______ Occupation: ______________________

Home Address: ______________________ Primary Phone #: ______________________

______________________ Alternate Phone #: ______________________

______________________ ` ______ May I leave messages? ______________________

Household Information

With whom does the child live? ______________________

Other people in household (Names & Ages):

____

____

____

____

What changes would you like to see in your child? ______________________

____

____

____

____

I authorize ADD SOI Testing Center and The ADD Diagnosis and Treatment Center to provide psychological services, including assessments, for the child name above.

X______________________ Date: ______________________
(Parent or Guardian's signature)

PreNatal History

Length of pregnancy: _________________ Weight at birth: __________________ Length at birth: _________________

Was delivery normal, breeched or cesarean section? ____________________________

Were there any pregnancy complications? ____

Medications used during pregnancy: ____

Did mother smoke cigarettes during pregnancy? ____ Did mother use any type of recreational drugs during pregnancy? ____

Did mother drink alcohol during pregnancy? If yes, what type and how often: _____________________________________

Infancy and Early Childhood

Please circle all that apply:

Colicky	Did not enjoy cuddling	Feeding problems	Headbanging
Sleeping problems	Accident prone	Restlessness	Active

Child's approximate age when began: Crawling: ________ Walking: ________ Talking (single words): _________

Speaking short sentences: __________ Toilet training: ________ Daytime: __________ Nighttime: ________________

Childhood

Was there any childhood surgery? ____

Any other hospitalizations? ____

Please circle any of the following diseases your child has or had:

Anemia	Lead poisoning	Meningitis	Heavy Metal Toxicity
Encephalitis	Seizures	Epilepsy	Cerebral Palsy
Other:_________________			

History of ear infections? Yes/No If yes, frequency and years__________________Antibiotics taken? _____________________

Tubes in ears? Yes/No If yes, what year put in and what year taken out, (please indicate if tubes still in) ______________________

Please list any unusual or traumatic events in this child's life, and the age of which they occurred:

____

____

____

____

____

Family History

Please circle if your child, a family member or an extended family member (e.g. cousins, aunts, uncles, grandparents) has had any of the following. Please specify the relationship of the family member to the child.

	Child	Family /Extended Family Member
Mental Health		
AD/HD	Yes No	Yes No If yes, who: ______________________________
ADD	Yes No	Yes No If yes, who: ______________________________

Dyslexia	Yes No	Yes No If yes, who: ________________
Depression	Yes No	Yes No If yes, who: ________________
Anxiety	Yes No	Yes No If yes, who: ________________
Obsessive-compulsive	Yes No	Yes No If yes, who: ________________
Bi-polar disorder	Yes No	Yes No If yes, who: ________________
Psychiatric illness	Yes No	Yes No If yes, who: ________________
Other:	Yes No	Yes No If yes, who: ________________

Traits	Child	Family /Extended Family Member
Procrastinates	Yes No	Yes No If yes, who: ________________
Easily distracted	Yes No	Yes No If yes, who: ________________
Impatient/Irritable	Yes No	Yes No If yes, who: ________________
Impulsive	Yes No	Yes No If yes, who: ________________
Packrat	Yes No	Yes No If yes, who: ________________
Time management problems	Yes No	Yes No If yes, who: ________________
Often overwhelmed	Yes No	Yes No If yes, who: ________________
Disorganized	Yes No	Yes No If yes, who: ________________
Chronically late	Yes No	Yes No If yes, who: ________________
Can’t complete tasks started	Yes No	Yes No If yes, who: ________________

Medical Conditions	Child	Family /Extended Family Member
Head injury	Yes No	Yes No If yes, who: ________________
Thyroid	Yes No	Yes No If yes, who: ________________
Seizures	Yes No	Yes No If yes, who: ________________
Allergies	Yes No	Yes No If yes, who: ________________
Tics or spasms	Yes No	Yes No If yes, who: ________________
Sleep disorders	Yes No	Yes No If yes, who: ________________
Asthma	Yes No	Yes No If yes, who: ________________
Diabetes	Yes No	Yes No If yes, who: ________________
Alcoholism/Drug addiction	Yes No	Yes No If yes, who: ________________

Previous Assessments	Child	Family /Extended Family Member
ADD or ADHD	________________	________________
	Date(s): ________________	Outcome: ________________
	Location: ________________	________________

Please list any known learning disabilities of school problems that your child has or other family members had:

____

____

____

____

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Please rate your child using the following scale:

DK- Don't Know 1-Never 2-Rarely 3-Sometimes 4-Often 5-Always

VISION OBSERVATIONS & SYMPTOMS	RATING SCALE	COMMENTS
1. Eyes feel uncomfortable, sore or strained when reading	DK 1 2 3 4 5	________
2. Problems understanding/remembering what you read	DK 1 2 3 4 5	________
3. Often skip, lose your place or reread words/lines	DK 1 2 3 4 5	________
4. Experience double vision when reading	DK 1 2 3 4 5	________
5. Transposition of letters or numbers (was-saw, 21-12)	DK 1 2 3 4 5	________
6. Sensitive or fatigued by bright lights/glare/sunlight	DK 1 2 3 4 5	________
7. Feel there isn't enough/too much light when reading	DK 1 2 3 4 5	________
8. Experiences headaches associated with visual tasks	DK 1 2 3 4 5	________
9. Words move/jump/float when reading	DK 1 2 3 4 5	________
10. Words blur or come in and out of focus when reading	DK 1 2 3 4 5	________
11. Ever wore an eye patch?	DK 1 2 3 4 5	________

AUDITORY/LANGUAGE PROCESSING	RATING SCALE	COMMENTS
1. Slow processing/delayed response	DK 1 2 3 4 5	________
2. Oversensitivity to certain/loud sounds	DK 1 2 3 4 5	________
3. Difficulty with phonics	DK 1 2 3 4 5	________
4. Requests instructions to be repeated	DK 1 2 3 4 5	________
5. Difficulty with spelling	DK 1 2 3 4 5	________
6. Misunderstands what you say	DK 1 2 3 4 5	________
7. Gets "confused" in noisy situations	DK 1 2 3 4 5	________
8. Difficulty expressing self verbally	DK 1 2 3 4 5	________
9. Mumbles/Stutters (note if speech class past or present)	DK 1 2 3 4 5	________
10. Mispronounces typical word Sounds	DK 1 2 3 4 5	________
11. Voice volume too loud or too soft (circle one)	DK 1 2 3 4 5	________

COORDINATION/SENSORY INTEGRATION	RATING SCALE	COMMENTS
1. Tires more easily or seems weaker than other kids	DK 1 2 3 4 5	________
2. Clumsy, bumps into things	DK 1 2 3 4 5	________
3. Poor motor coordination, i.e. catching a ball	DK 1 2 3 4 5	________
4. Poor balance or rhythm	DK 1 2 3 4 5	________
5. Attracted to moving activities (swinging, spinning, etc)	DK 1 2 3 4 5	________
6. Confusion of left and right side of body	DK 1 2 3 4 5	________
7. Difficulty hopping, jumping, or skipping	DK 1 2 3 4 5	________
8. Messy Handwriting	DK 1 2 3 4 5	________

9. Difficulty using scissors, buttons, or zippers	DK 1 2 3 4 5	______________________
10. Lack of motion sensitivity—never gets dizzy	DK 1 2 3 4 5	______________________
11. Reacts negatively or emotionally to being touched	DK 1 2 3 4 5	______________________
12. Bothered by clothes, textures, shirt collars, tags, hats	DK 1 2 3 4 5	______________________
13. Accident prone	DK 1 2 3 4 5	______________________

<u>**ACADEMIC PERFORMANCE**</u>	**RATING SCALE**	**COMMENTS**
1. Poor academic/study skills	DK 1 2 3 4 5	______________________
2. Trouble organizing, finishing or turning in schoolwork	DK 1 2 3 4 5	______________________
3. Trouble with math computations/concepts	DK 1 2 3 4 5	______________________
4. Trouble with reading comprehension	DK 1 2 3 4 5	______________________
5. Trouble with essay writing	DK 1 2 3 4 5	______________________
6. Trouble with language/grammar/spelling	DK 1 2 3 4 5	______________________
7. Spends too long on homework	DK 1 2 3 4 5	______________________
8. Needs extra help in schoolwork and/or works slowly	DK 1 2 3 4 5	______________________
9. Class clown	DK 1 2 3 4 5	______________________
10. Poor test taker	DK 1 2 3 4 5	______________________
11. Poor memory	DK 1 2 3 4 5	______________________
12. Avoidance of schoolwork/ works too hard on work	DK 1 2 3 4 5	______________________
13. Has been or currently in special ed/resource class	DK 1 2 3 4 5	______________________

<u>**BEHAVIOR**</u>	**RATING SCALE**	**COMMENTS**
1. Temper tantrums	DK 1 2 3 4 5	______________________
2. Lies	DK 1 2 3 4 5	______________________
3. Defiant	DK 1 2 3 4 5	______________________
4. Disruptive	DK 1 2 3 4 5	______________________
5. Lack of self-control/Impulsive	DK 1 2 3 4 5	______________________
6. Hyperactive/Fidgety	DK 1 2 3 4 5	______________________
7. Difficulty making transitions	DK 1 2 3 4 5	______________________
8. Lack of motivation	DK 1 2 3 4 5	______________________
9. Repetitive behaviors (washing hands, touching, etc)	DK 1 2 3 4 5	______________________
10. Destructive	DK 1 2 3 4 5	______________________
11. Steals	DK 1 2 3 4 5	______________________

<u>**SOCIAL SKILLS**</u>	**RATING SCALE**	**COMMENTS**
1. Shy	DK 1 2 3 4 5	______________________
2. Few friends/doesn't make friends easily	DK 1 2 3 4 5	______________________
3. Bullies others	DK 1 2 3 4 5	______________________

4. Isolative DK 1 2 3 4 5 ______
5. Poor communication skills DK 1 2 3 4 5 ______
6. Overly Talkative/Interrupts others DK 1 2 3 4 5 ______

EMOTIONAL **RATING SCALE** **COMMENTS**

1. Low self esteem DK 1 2 3 4 5 ______
2. Excessively emotional DK 1 2 3 4 5 ______
3. Cries easily/often DK 1 2 3 4 5 ______
4. Easily frustrated DK 1 2 3 4 5 ______
5. Sad/sullen DK 1 2 3 4 5 ______
6. Angry/quick tempered DK 1 2 3 4 5 ______
7. Immature compared to other kids their age DK 1 2 3 4 5 ______

DIET/NUTRITION **RATING SCALE** **COMMENTS**

1. Eats fast food DK 1 2 3 4 5 ______
2. Eats pre-packaged/processed food DK 1 2 3 4 5 ______
3. Rarely eats home-cooked meals DK 1 2 3 4 5 ______
4. Picky eater DK 1 2 3 4 5 ______
5. Dislikes certain foods because of texture i.e. too mushy DK 1 2 3 4 5 ______
6. Allergies to certain foods DK 1 2 3 4 5 ______
7. Overeats/Undereats DK 1 2 3 4 5 ______
8. Overweight/Underweight DK 1 2 3 4 5 ______
9. Eats dairy (milk, cheese, yogurt, ice cream, cream cheese) DK 1 2 3 4 5 ______
10. Eats cereal or other carbs for breakfast DK 1 2 3 4 5 Type: ______
    a. If rated 1-3, what else? ______
11. Eats out or school provided lunch DK 1 2 3 4 5 ______
    a. If rated 1-3, then where else is lunch obtained? ______
12. Eats out for dinner DK 1 2 3 4 5 ______
    a. If rated 1-3, then where else is dinner obtained? ______
13. What kinds of snacks are eaten? ______
14. Currently taking supplements? Yes No ______
    a. If yes, which ones? ______
15. Currently taking multi-vitamin? Yes No ______
    a. If yes, what brand? ______

EXERCISE/EXTRACURRICULAR ACTIVITIES **RATING SCALE** **COMMENTS**

1. Exercises or does physical activity on a daily basis Yes No ______
2. Plays sports Yes No ______

a. If yes, what sports: ______________________________

b. Competitively? ______________________________

3. Involved in other physical extracurricular activities Yes No ______________

a. If yes, what kinds? ______________________________

4. Involved in other non-physical extracurricular activities? Yes No ______________

a. If yes, what kinds? ______________________________

5. Plays musical instruments Yes No ______________

a. If yes, which ones? ______________________________

INJURIES/ACCIDENTS

1. Ever fallen and hit head/had concussion? Yes No ______________

a. If yes, date: ______________ Description: ______________

2. Ever been in a serious car accident or other accident Yes No ______________

a. If yes, date: ______________ Description: ______________

3. Ever had any major surgeries? Yes No ______________

a. If yes, date: ______________ Description: ______________

4. Ever had neck or back injuries? Yes No ______________

a. If yes, date: ______________ Description: ______________

5. Any other major injuries? Yes No ______________

a. If yes, date: ______________ Description: ______________

MEDICATION **RATING SCALE COMMENTS**

1. Currently taking medication? Yes No ______________

a. If yes, type and dosage ______________________________

b. Prescribing Dr. ______________________________

c. List any side effects: ______________________________

2. Taken medication before? Yes No ______________

a. If yes, type and dosage ______________________________

b. Prescribing Dr. ______________________________

c. List any side effects: ______________________________

3. Open to Medication? Please circle: Yes As last resort Need more info No

Please use this space to tell us about anything else that you think is important to know about your child:

____

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