

Hook Psychological Services, PLLC
2505 S. 17th St, Suite 200
Wilmington, NC 28401
(910) 254-4545

Dear Parent(s)/Guardian(s):

I am excited to be working with you and your child soon. Enclosed are several forms that need to be completed *prior* to your child's initial appointment.

The following forms are included within this packet:

1. Background History Form
2. Billing/Insurance Paperwork
3. What to Expect: Preparing For Your Child's First Visit

Please **complete and return** these forms to the following address *as soon as possible*:

Attention: Intake
Potentials
2505 S. 17th St, Suite 200
Wilmington, NC 28401

If any questions or concerns arise as you complete these forms, please to call my office staff at **910-254-4545**.

I look forward to seeing you soon!

Intake Packet for Assessment Clients

Background Information Form

The purpose of this questionnaire is to gather information about your child and family before the intake appointment. Your answers will allow Dr. Hook to plan the assessment specifically for your child. Do not worry if you do not have all of the information to answer every question, as we will be discussing this further at the intake appointment. Your time and effort in completing this questionnaire is greatly appreciated!

General Information

Date: _____ Form Completed By: _____ Relationship to Child: _____

Child's Name: _____

(First)

(Middle)

(Last)

("Nick Name")

Date of Birth: _____ Sex: _____ Grade: _____

Name of School: _____ School District: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Best Phone # _____ Best Phone # _____

Occupation _____ Occupation _____

Highest Grade Completed _____ Highest Grade Completed _____

Best email address to contact you _____.

Does your child have other parent(s)/stepparent(s)/primary caregivers? Yes No

If yes, please provide the following information:

Name: _____ Name: _____

Address: _____ Address: _____

Phone # _____ Phone # _____

Relationship to this child: _____ Relationship to this child: _____

Occupation _____ Occupation _____

Highest Grade Completed _____ Highest Grade Completed _____

Is your child adopted? Yes No

With what adult(s) does this child live? _____

At what age did the child come into the current living situation? _____

Child's Name _____

Child's DOB _____

Please list ALL brothers and sisters, AND any other children living in the home with the client.

Age	Sex	Relationship to this Child	Living at home?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How does your child relate to (or “get along” with) other family members? _____

Language(s) other than English spoken in home: _____

Have there been any recent changes or stresses in the family/home? Yes No

If yes, please describe: _____

Pregnancy and Birth History

Number of Pregnancies of the child’s biological mother? _____

During the pregnancy with the child, was/did the mother:

	<u>Yes</u>	<u>No</u>	<u>Further Description</u>
Under a doctor’s care?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Experience infection or other illness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have toxemia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have unusual physical strain or injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have unusual emotional strain?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drink alcoholic beverages? (please indicate how much)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoke cigarettes? (please indicate how much)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Take medications or drugs? (other than vitamins/iron)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other complications?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Estimated length of pregnancy: _____ (weeks)

Type of labor onset: Induced Spontaneous

Length of Labor: _____

Type of delivery: Vaginal Cesarean

Type of anesthesia: Gas Spinal None

Child's Name _____

Child's DOB _____

Baby's Presentation: Breech Head

Did any complications occur during delivery? Yes No

If yes, please check if any of the following occurred:

Toxemia/Pre-eclampsia Maternal Fever Fetal Distress Medications Used: _____

In addition, were any specialized procedures used (e.g., forceps, suction) during delivery? Yes No

If yes, please state: _____

Birth weight: _____ lbs _____ oz Apgar Scores, if known: _____ 1 min _____ 5 min _____ 10 min

What was the baby's condition following delivery? _____

Please describe any specialized treatment provided to baby following delivery: _____

What was the mother's condition following delivery? _____

Length of hospital stay following delivery: _____ Mother _____ Baby

Check any of the following which occurred during your baby's first month of life:

- Breathing Problems Convulsions Skin Rash Excessive Vomiting Injury
 Jaundice (yellow) Infection Birth Defect Excessive Crying Feeding Difficulty

Health and Medical History

Who is your child's primary care physician? _____

Has your child had any of the following:

	<u>Yes</u>	<u>No</u>	<u>During What Ages?</u> (e.g., 3 months to 2 years)
Convulsions, seizures, fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision or eye problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, approximately how many ear infections has your child had? _____			
Have PE tubes been inserted?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, more than once? _____ How many times? _____			
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, what is your child allergic to? _____			
Any serious accidents or injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any poisoning or overdose?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any problems with weight gain or loss?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any surgeries <u>or</u> overnight hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, what surgeries or procedures and why? _____			

Child's Name _____

Child's DOB _____

	<u>Yes</u>	<u>No</u>	<u>During What Ages?</u> (e.g., 3 months to 2 years)
Any other chronic or serious health problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any history of lead poisoning or other toxin exposure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any severe reaction to an immunization?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a medical check-up within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If any health problems or recommendations, what/by whom? _____			
What medications is your child currently taking? _____			
Has your child ever been given a diagnosis (e.g., ADHD)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If so, please state diagnosis? _____			

Developmental History

Please comment on when your child did the following things:

<u>Action</u>	<u>Time</u> (please circle)	<u>Approximate Age</u> (in months)
Roll over (tummy to back)	seemed early / seemed on time / seemed late	_____
Roll over (back to tummy)	seemed early / seemed on time / seemed late	_____
Sit up with support	seemed early / seemed on time / seemed late	_____
Sit up without support	seemed early / seemed on time / seemed late	_____
Crawl	seemed early / seemed on time / seemed late	_____
Pull up to stand on furniture	seemed early / seemed on time / seemed late	_____
Walk alone	seemed early / seemed on time / seemed late	_____
Give up his/her bottle	seemed early / seemed on time / seemed late	_____
Drink from sipper top cup	seemed early / seemed on time / seemed late	_____
Drink from regular cup	seemed early / seemed on time / seemed late	_____
Finger feed self	seemed early / seemed on time / seemed late	_____
Feed self with a spoon	seemed early / seemed on time / seemed late	_____
Dress Self	seemed early / seemed on time / seemed late	_____
Undress Self	seemed early / seemed on time / seemed late	_____
Achieve toilet training for bladder	seemed early / seemed on time / seemed late	_____
Achieve toilet training for bowels	seemed early / seemed on time / seemed late	_____
Smile	seemed early / seemed on time / seemed late	_____
Coo	seemed early / seemed on time / seemed late	_____
Babble (da-da-da, ba-ba-ba)	seemed early / seemed on time / seemed late	_____
Jargon (talk in own special language)	seemed early / seemed on time / seemed late	_____
Say single words	seemed early / seemed on time / seemed late	_____

Child's Name _____

Child's DOB _____

Does your child have a best friend? Yes No

If yes, how old is he/she? _____ How long have they been friends? _____

What are your child's main hobbies or interests? _____

Please list the things your child does well: _____

What are the most positive features about your child? _____

Are there behavior problems at school? Yes No

If yes, please describe _____

Are there behavior problems at home? Yes No

If yes, please describe _____

Family Medical, Emotional, and Learning History

Biological mother's age and general health: _____

Biological father's age and general health: _____

Please check to indicate if any of the child's *biological* family members have had the following conditions:

Condition	Immediate Family			Father's Relatives			Mother's Relatives		
	Dad	Mom	Sib	Dad	Mom	Sib	Dad	Mom	Sib
Down Syndrome									
Autism									
Mental Retardation									
Learning Difficulties									
Reading									
Written Language									
Mathematics									
Oral Language									
Hydrocephalus									
Language/Speech Delay									
Hyperactivity									
Attention Deficit									
Conduct Problems									
Drug/Alcohol Abuse									
Neurological Disorders (Please specify)									
Epilepsy/Seizures									

Child's Name _____

Child's DOB _____

Condition	Immediate Family			Father's Relatives			Mother's Relatives		
	Dad	Mom	Sib	Dad	Mom	Sib	Dad	Mom	Sib
Tics									
Depression									
Anxiety									
Panic Attacks									
Obsessive-Compulsive Disorder (OCD)									
Diabetes or Hypoglycemia									
Hearing Loss									
Vision Problems									
Held back in school									
Muscular problems/weakness									
Other: _____									

Reason(s) for Current Appointment

Who recommended or referred your child for this appointment? _____

What questions or concerns would you like addressed/answered? _____

What do you feel led to/caused these concerns? _____

When did you first notice these concerns? _____

Additional Comments (If needed, please use the backside of this page.)

What to Expect for a Psychological Evaluation/Testing Appointment

When your child has been scheduled for an evaluation appointment, here are a few suggestions to help make the experience a more positive one.

1. It has been helpful for many parents to explain the visit as a “Learning Check-Up”.
2. Tell a younger child that he or she will be doing “learning activities” like listening, solving puzzles, and reading. Please do not set the expectation that your child is coming to *play games*. Although many children do enjoy “showing off” what they have learned, your child will be taking challenging tests and over-selling the appointment as a “fun” thing may prove counter-productive.
3. Tell a younger child that this is *not* a physician appointment; no one will use needles, etc.
4. For an older child who expresses concern over the stigma of an evaluation or fear that having this assessment means that he or she is “stupid”, “crazy”, or “mental”, you may wish to reassure him/her that everyone deals with periodic challenges. Coming in for an evaluation does not mean he or she has done anything wrong; rather, this appointment is an opportunity to find out his or her strengths and weaknesses and perhaps identify some new ways of dealing with things to make home, school, and/or social life go more smoothly.
5. If your child’s appointment is longer than two hours, it will probably be helpful to bring a snack and a drink.
6. If your child’s appointment is scheduled to last four or more hours, an hour break will be scheduled for lunch.
7. Tell your child that it is “OK” if he or she doesn’t know everything.
8. Parents’ undivided attention is needed during the separate *feedback session*. It is generally considered best not to have your child in attendance during that time (the exception would be a college-bound high school senior or college-age student).
9. High school age clients are encouraged to attend an additional, separate feedback session for approximately 20 minutes during after school hours following the parent feedback appointment. The purpose of this session is to broadly go over the major findings (e.g., talk about strengths and weaknesses, not specifics, like IQ score) and, if appropriate, to explain why a diagnosis was made or certain recommendations given. ***PLEASE MAIL COPIES OF ANY PAST EVALUATION REPORTS, STANDARDIZED TEST SCORES, AND REPORT CARDS BEFORE THE APPOINTMENT, IF POSSIBLE.***
10. Every effort is made to get you the complete evaluation report as quickly as possible; however, given the length and detail of reports for full evaluations, **it can take up to 4 weeks from the date of the feedback appointment for you to receive the dictated report in the mail.** For time sensitive matters, the psychologist can provide brief/ summary letters to physicians, schools, etc. in advance of the full report to facilitate interventions or placement decisions. Please inform the psychologist of these sorts of time-sensitive needs as soon in the process as you are aware of them.