Dr. Michelle Spader
Licensed Clinical Psychologist • Board Certified Behavior Analyst
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Intake Form

-Please be sure to bring any previous evaluation reports, such as school MFE/ETR and IEP, previous psychological evaluations, and any recent speech or occupational therapy evaluations to your appointment.

Person Completing this form _____ Relationship to Child _____

Today's Date:_____ Child's Name: _____

Child's Date of Birth: _____ Child's Gender: □Male □Female □ Other: _____

Home Address: _____
Street City State Zip County

Parent's Name: _____ Parent's Name: _____

Parent's Home #: _____ Parent's Home #: _____

Parent's Cell #:_____ Parent's Cell #: _____

Parent's Work #: _____ Parent's Work #: _____

Email Address: _____ Email Address: _____

Preferred method of contact: Preferred method of contact:

□ Email □ Cell □ Home Phone □ Work Phone □ Email □ Cell □ Home Phone □ Work Phone

Guardian's Name (if different than above): _____

Child's Pediatrician: _____ Phone#: _____ Fax#: _____

Address: _____
Street City State Zip

If you would like Dr. Spader to fax a copy of completed records to your child's pediatrician such as the Psychological Assessment Results Report, please check here: □yes □no

Referral History:

1. Who referred your child for psychological assistance?
□ Physician □ School □ Employer □ Friend □Insurance Company □ Internet Search □ Other: _____

2. Briefly describe the chief problems that are affecting your child and your family: _____
_____

3. In what way are you hoping that Dr. Spader can be helpful with these problems? _____
_____

4. Does your child have any previous diagnoses (medical or mental health-related): _____
_____

5. Please list your child's strengths, what s/he is good at, and/or what s/he likes to do: _____
_____
_____

Health Status:
Is your child taking any medications on a regular basis? □yes □no
If yes, please list medicines and reasons why child is taking them: _____

Please list any current health/medical issues _____

Has your child ever engaged in the following? (check if yes)
Tobacco Use __ Alcohol Use ___ Drug Use _____ Sexual Activity _____

Services History:
1. Check if your child has received or is currently receiving any of the following services:

Help Me Grow		County Board of Developmental Disabilities	
Head Start		Academic Tutoring	
Speech/Language Therapy		Social Security	
Physical Therapy		Counseling/Therapy	
Occupational Therapy		Other: _____	

2. Has your child ever received a psychological evaluation (cognitive, academic, etc.)? □yes □no
If yes, who performed the evaluation(s) and when did they occur?_____

3. Has your child ever received any medical testing (e.g., EEG, MRI, genetics)? □yes □no
If yes, what were the tests and when did they occur? _____

Please bring a copy of the reports from previous evaluations discussed above.

Medical History:
Mother's age when child was born _____ Any previous miscarriages/stillbirths? □yes □no

Length of pregnancy/Age of gestation _____ weeks Child's birth weight _____lb_____oz

Delivery was (check all that apply): □Natural vaginal birth □ Induced Vaginal birth □C-section □ Emergency C-section
□ Breech position □ Forceps used □ Vacuum extraction used

How many days in hospital? _____ Was child in NICU? □yes □no If yes, please explain: _____

Problems with pregnancy (If yes, please describe; e.g., bleeding, bedrest, serious injury or illness to mother, toxemia/high blood pressure, diabetes, alcohol use, drug use, smoked cigarettes, took prescription medications): _____

Problems with delivery (If yes, please describe; e.g., emergency C-section, slow heart rate, fever, cord around neck, toxemia, etc.): _____

Problems after birth (If yes, please describe; e.g., trouble breathing, turned blue, needed oxygen, jittery, birth defects and/or special care needed such as blood transfusions, oxygen, incubator, medications): _____

Does your child have a history of any of these medical conditions? (check if yes)

Neurological problems		Hearing problems		Hospitalizations	
Growth problems		Chronic Ear Infections		Surgery/Operations	
Dental problems		PE Tubes		Lead poisoning/Other poisoning	
Eating/appetite problems		Eye or vision problems		Sleep Problems	

Comments: _____

Developmental History:
Is your child toilet trained? □yes (Age completed:_____) □no
Does your child still experience toileting accidents during the: □Day □Night

Has your child experienced any of the following? (check if yes)

Speech/Language problems		Seems depressed		Social problems	
Fine motor problems (use of hands, writing, fasteners)		Seems anxious/nervous		Academic problems	
Gross motor problems (use of large muscles for walking/running, clumsy)		Involved with Child Protective Services		Experienced a trauma (e.g., major accident, abuse)	
Problems with daily living skills (getting dressed, feeding self)		Involved in legal system		Behavior Problems (tantrums, aggression, defiance, etc.)	
Sexual Problems		Thoughts of Suicide/Self-Harming Behavior		Thoughts of Homicide	

Comments: _____
_____

School History:
Did your child attend special needs preschool? □yes □no If yes, how many years of attendance(s): _____

Age at Kindergarten entrance: _____ Current Grade: _____

Has your child ever repeated a grade? □yes □no If yes, what grades?_____

Grade when Individualized Education Plan (IEP) started, if applicable: _____

Has your child ever been placed in a special educational program or classroom? □yes □no
Please describe arrangement (number of teachers/aides, number of students, any typical peers, time in mainstream classroom, etc.): _____

Are there concerns about your child's ability to learn or with his/her behavior at school? □yes □no
If yes, please explain (what are the concerns, when did these concerns begin): _____
_____

Family History:

Which of the following racial backgrounds best describes… (place a check mark)	Child	Biological Mother	Biological Father
White, not of Hispanic origin			
African-American or Black, not of Hispanic origin			
Hispanic/Latino			
Native American Indian or Alaskan Native			
Asian, Asian-American, or Pacific Islander			
Other			

Does your child or family have any cultural or religions preferences or restrictions? □yes □no
If yes, please explain:_____

Please mark your religious affiliation (if any)	Please mark any other relevant cultural background with which you identify
Catholic	Amish
Jewish	Appalachian
Jehovah Witness	Somalian
Muslim	Other
Protestant	
Seventh Day Adventist	
Latter Day Saints	
Other	

Main language spoken in your home:
Other languages spoken in the home (please list):

Parents are (please circle): Married Separated Divorced Never Married Widowed Deceased

If parents are separated or divorced, who has legal custody? Both/Joint Mother Father Other

If Both/Joint, is the child's other parent aware that you are pursing these psychological services? □yes □no

Please describe custody and visitation arrangements, including how often the child sees the parent that s/he does not live with: _____

*Please be aware that both custodians have access to all medical records unless there is a court order stating otherwise.
*Additionally, if you are bringing your child in for services, and you are divorced/separated from the child's other biological parent, you are responsible for paying any fees associated with my psychological services regardless of which parent the insurance policy is under.

Is this child a foster child? □yes □no Is this child adopted? □yes □no
If yes, how long has the child been in your home? _____

If yes, is this child aware that s/he is a foster or adopted child? □yes □no

If yes, please give as much information regarding biological parent(s) as you can: _____

_____

Parent's Name:_____ Age: _____ Highest level of education completed:

Grade School (grades 1-8)		Some College	
High School, but didn't graduate		College Graduate	
High School, Completed		Post Graduate Level	
Training after High School, other than college			

Occupation:_____
Place of Employment:_____ Work Hours:_____

Parent's Name:_____ Age: _____ Highest level of education completed:

Grade School (grades 1-8)		Some College	
High School, but didn't graduate		College Graduate	
High School, Completed		Post Graduate Level	
Training after High School, other than college			

Occupation:_____
Place of Employment:_____ Work Hours:_____

Step-parent's name (if applicable):_____ Time known child: _____
Step-parent's name (if applicable):_____ Time known child: _____

Who is living in the home at this time? (Please include everyone).

Name	Age	Relationship to Child

Family members living outside of the home. (For example, a biological parent, brothers or sisters).

Name	Age	Relationship to Child

Continued on next page.

Problem Areas for Family Members:
Has anyone in your family experienced the following (check if yes):

Problem	Check if Yes	Relationship to Child
ADHD		
Anxiety		
Autism Spectrum Disorder		
Behavior Problems		
Bipolar Disorder/Manic Depression		
Depression		
Drug Abuse		
Learning Disability (reading, writing, or math)		
Intellectual Disability/Cognitive Delays		
Language/Speech Disorder		
Suicide Attempt/Completion		
Victim of Physical/Sexual Abuse		
Seizures		
Genetic Syndrome/Disorder		
Other: _____		

Additional Information
Please add any additional information that you believe will help Dr. Spader to better understand your child.

_____
_____
_____
_____
_____

Thank you for taking the time to complete this form.
Please bring this completed form to your first appointment, email it to contact@spaderpsychology.com, fax to (614) 852-4151, or mail to Dr. Spader, 6260 South Sunbury Road, Suite 5, Westerville, OH 43081.

Please also bring additional paperwork and reports such as
- school Evaluation Team Report (ETR)
- school Individualized Education Plan (IEP)
- previous medical or psychological evaluations
- previous speech evaluations

Dr. Spader is looking forward to meeting with you and your child.

Insurance Information: Please bring your insurance card with you to the first visit. Additionally, Dr. Spader will contact your insurance company to pre-authorize services. However, this does not guarantee insurance benefits for your appointment(s).

Signature of parent/guardian: _____ Date: _____