GLENWOOD

A Continuum of Care

Intake for Outpatient Services (please check which service you require)

- ☐ Testing _____
- ☐ F.A. C. S Program
- ☐ Counseling
- ☐ Social Skills Group
- ☐ Speech
- ☐ Parent-Child Interaction Therapy
- ☐ A.B.A. Services
- ☐ OT

Thank you for your interest in Glenwood's outpatient services. Before we can begin the scheduling process, we need to have all attached documents filled out and sent back. Once ***all*** information is received, you will be put on our waiting list, the times of which vary depending on what services you are seeking. Below you will find a checklist of required documents. **Please make sure you have checked off the list so that we know what documents should be present when we receive it.**

Please review the checklist below. **All information below must be included with your completed questionnaire for your child to be put on our waiting list for an appointment.** If you have any questions about these requirements, please call **205-939-1088**.

_____ **Completed Intake Questionnaire**

_____ **Copy of insurance card (front and back)**

_____ **Copy of any guardianship, custody, divorce/visitation agreements (if applicable)**

_____ **Copy of any previous psychological testing**

_____ **Copy of any IEPs (**testing & eligibility portion with scores)**

*****Please note that if any of the required information or documents are left out, this will prevent you from having an appointment scheduled (this includes providing us with the social security number, which we must have for billing purposes).**

Send completed forms to:

Lisa Braxton

614 38TH Street South
Birmingham, Al 35222
P: (205) 939-1088
F: (205) 212-6688
lbraxton@glenwood.org

Name:_____ Date:_____

DIAGNOSTIC TESTING/TREATMENT INFORMATION

Please complete this form in full

Please provide information regarding any or **ALL** previous or **PENDING** evaluations or treatment

Has your child been recently evaluated by their school (within the past 12 months)?
_____ yes ____no
Has your child been recently evaluated by another psychologist (within the past 12 months)?
_____yes _____no

List all previous evaluations. Copies of evaluation(s) must be sent back with the intake packet.

_____School Evaluation	Provider?_____	Date:_____
_____Speech/Hearing	Provider?_____	Date:_____
_____Neurological (EEG, CT, MRI)	Provider?_____	Date:_____
_____Psychiatric	Provider?_____	Date:_____
_____Psychological/ Counseling	Provider?_____	Date:_____
_____Occupational Therapy	Provider?_____	Date:_____
_____Physical Therapy	Provider?_____	Date:_____
_____Developmental	Provider?_____	Date:_____
_____Genetic	Provider?_____	Date:_____
_____Other	Provider?_____	Date:_____

Previous/Current Diagnoses (please check all that apply)

_____Developmental Delay	Provider?_____	Date:_____
_____Autism Spectrum (PDD-NOS, Asperger's)	Provider?_____	Date:_____
_____Neurological	Provider?_____	Date:_____
_____Speech Language Delay	Provider?_____	Date:_____
_____Intellectual Disability/ Mental Retardation	Provider?_____	Date:_____
_____Social Delays	Provider?_____	Date:_____
_____Learning Disorder	Provider?_____	Date:_____

_____Reading _____Math _____Written Expression _____Oral Expression

_____ADHD/ADD	Provider?_____	Date:_____
_____Tic Disorder	Provider?_____	Date:_____
_____Oppositional Defiant Disorder	Provider?_____	Date:_____
_____Anxiety Disorder/OCD	Provider?_____	Date:_____
_____Depression	Provider?_____	Date:_____
_____Bipolar Disorder	Provider?_____	Date:_____
_____Psychosis	Provider?_____	Date:_____

Is or has your child currently receiving any of the following?

_____Psychiatric Medications
_____Speech Therapy
_____Physical Therapy
_____Counseling
_____Occupational Therapy
_____Other type of therapy

If yes, please list names of those who provided service and dates services received.

_____

_____

_____

If child is currently receiving Early Intervention Services or enrolled in public and/or private school, please provide the following information:

Under what special education exceptionality is the child receiving services?

_____Autism
_____Intellectual Disability
_____Multiple Disabilities
_____Other Health Impairment
_____Speech or Language Impairment
_____Visual Impairment
__X__Developmental Delay
_____Emotional Disability
_____Orthopedic Impairment
_____Specific Learning Disability
_____Traumatic Brain Injury
_____Hearing Impairment

What services is the child receiving related to his/her exceptionality?_____

_____

_____

_____

Please attach ALL diagnostic reports with this packet. This will also include the child's most current IEP or IFSP.

Pediatric Symptom Checklist (PSC) +

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety, unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by a motor	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor with doctor finding nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			

Score 1-35 _____

36. Has difficulty making eye contact/looking you in the eye	36			
37. Has difficulty keeping conversation going with peers/others	37			
38. Often plays alone or avoids playing or interacting with others	38			
39. Has an intense or unusual interest lasting more than a year	39			
40. Displays unusual, repetitive hand or body movements	40			
41. Is overly sensitive to sounds, touch, or smells	41			
42. Has difficulty with changes in routine or activity	42			

Score for 36-42 _____

Parent/Guardian Questionnaire

Glenwood Inc.

Date: _____ Form completed by: _____ Relationship to client: _____

Insurance: _____ Policy Name and #: _____

Secondary Insurance: _____ Policy Name and #: _____

Family Data

Client's Name: _____ Birthdate: _____ Age: _____

Gender: Male _____ Female _____ Ethnicity: _____ SS# _____ Home # _____

Home Address (**street, city, zip**): _____

County: _____

Father's Name: _____ DOB: _____ Education: _____

Employment: _____ Business Phone: _____

Father's email (optional): _____ Annual Income: _____

Mother's Name: _____ DOB: _____ Education: _____

Employment: _____ Business Phone: _____

Mother's email (optional): _____ Annual Income: _____

Best # to contact you: _____ Name child goes by: _____

Language parents speak _____ Language child speaks _____

Parents are: Married ____ Divorced ____ Separated ____ Widowed ____ Single/Never Married ____

Date _____ Date _____ Date _____ Date _____ Other (explain): _____

Client's legal guardian: Both Birth Parents ____ Birth Mother ____ Birth Father ____ Adoptive Parents ____

Department of Human Resources ____ Legal Guardian ____

Client lives with: Both Parents _____ Mother _____ Father _____ Other _____

List the names and ages of all siblings (step/ half siblings also):

Name	Age	Relationship (step/half)	Current Grade	Learning/ Medical Problems

Please list all individuals, and their relationship to the child, including parents who are currently living in the home:

_____

_____

Is this a Foster Home Placement? Yes ____ No ____ Adopted: Yes ____ No ____

Age at placement: _____ Age at adoption: _____

Other important/ influential people frequently in client's life (who do not reside in the home): _____

_____

Are there any current custody issues? Yes _____ No _____

If Yes, please explain: _____

If applicable, what are the custody or visitation agreements? _____

_____

Has the Department of Human Resources (DHR) ever been involved with this client? Yes _____ No _____

Dates of DHR involvement: _____

Reasons for DHR involvement: _____

_____

Do all parties involved in the care of the child agree on the need for an evaluation of this child? _____

_____

Who referred you to Glenwood Outpatient Services ? _____

Phone number: _____ Why were you referred? _____

_____

Chief problems as you see them:	When did the problems begin? (age or date)
1.	
2.	
3.	
4.	
5.	

Please indicate your **primary** area of concern from the following choices (select only **one** item):

___ Learning Problems ___ Autism/Developmental Delay ___ Attention/Hyperactivity

___ Mood/Depression ___ Anxiety/Obsessive-Compulsive Behavior ___ Psychotic Symptoms/Schizophrenia

___ Communication/Motor ___ Oppositional Behavior/Conduct ___ Other: _____

Please indicate if you have any secondary area of concern from the following choices (select only **one** item):

___ Learning Problems ___ Autism/Developmental Delay ___ Attention/Hyperactivity

___ Mood/Depression ___ Anxiety/Obsessive-Compulsive Behavior ___ Psychotic Symptoms/Schizophrenia

___ Communication/Motor ___ Oppositional Behavior/Conduct ___ Other: _____

Has his/her hearing been tested? Yes _____ No _____

If yes, who tested? _____ when tested? _____

What were the results? _____

Describe his/her response to sound (e.g., responds to all sounds, responds to loud sounds only, extremely sensitive to loud noises, etc.) _____

Has his/her vision been tested? Yes _____ No _____

If yes, who tested? _____ when tested? _____

What were the results? _____

Does he/she have difficulty walking, running, or participating in other activities that require small or large muscle coordination? Yes _____ No _____

If yes, please describe: _____

_____

Pregnancy History - Mother

While you were pregnant were you under a doctor's care? Yes _____ No _____

Mother's age at time of birth _____ Length of pregnancy _____

Miscarriages _____

During this pregnancy did you have:

Condition	Yes	No	Describe
Anemia			
Elevated Blood Pressure			
Toxemia/ Eclampsia			
Swollen Ankles			
Gestational Diabetes			
Placenta Previa			
Bleeding			
Measles			
German Measles			
Flu			
Other Virus			
Vomiting			
Injury			
Medication during pregnancy (prescription and over-the-counter)			
Emotional Problems			
Threatened miscarriage or early contractions			
Alcohol, drugs, tobacco use			Specify:
Other?			

Birth History

Were you given medication? Yes _____ No _____ What kind? _____

Did you have natural childbirth? Yes _____ No _____

Was labor induced? Yes _____ No _____ Was induced labor planned? Yes _____ No _____

Type of delivery: Head first_____ Feet first _____ Caesarian _____

Was the delivery unusual in any way or any complications? Yes _____ (How? _____) No _____

Did you have twins? Yes _____ No_____ Which born first? _____

Did this baby have: Breathing problems? Yes _____ No _____ Don't know _____

If yes was oxygen used? Yes _____ No _____

Cord around neck? Yes _____ No _____ Don't know _____

Did this baby cry quickly? Yes _____ No _____ Don't know _____

Was this baby's color normal? Yes _____ No _____ Blue? _____ Yellow?_____ Don't know _____

Was the baby premature? Yes _____ No _____ How much? _____

What did the baby weigh? _____ Apgar Scores? _____

Was baby in incubator? Yes _____ No _____ Neonatal Intensive Care? Yes _____ No _____

Did you take the baby home with you from the hospital? Yes _____ No _____ How long after? _____

Was the baby normally active? Yes _____ No _____ Describe: _____

Problems noted at birth or shortly after: _____

_____

Feeding

Did your child have problems with feeding as an infant? Yes _____ No _____ Describe: _____

Colic? _____ Vomiting? _____ Sucking Problems? _____ Swallowing Problems? _____ Chewing Problems? ____

Current weight: _____ Any growth problems/concerns? Yes _____ No _____

Is client on a special diet? Does he/ she take any nutritional supplements? If yes, please describe: _____

_____

Is client a picky eater? If so, what foods will he/ she eat? _____

_____

Describe his/her appetite and eating habits at present: _____

_____

_____

Development : Indicate age at which he/she began performing these behaviors

Sat unsupported: _____ Crawl: _____ Stood alone: _____ Walked: _____ First words: _____

2-Word Phrases: _____ First short sentences: _____ Bladder trained: _____ Bowel trained: _____

Out of diapers: _____

Your child's overall development compared to others his age:

_____Below Average _____Average _____Above Average

Were you ever concerned regarding any area of his/her development? _____ If yes, how old was he/she when you first became concerned? _____ What were your concerns?_____

_____

Did a regression of skills or a loss of skills ever occur in the client's development? Yes _____ No _____

If yes, when did this regression/ loss of skills occur? _____

If yes, please describe the regression/ loss of skills. _____

_____

He/She communicates by which of the following (Check all that apply):

Crying _____ Playful sounds _____ Pointing with index finger _____ Words _____

Phrases _____ Sentences _____ Sign Language _____ Picture Communication _____

How much of his/her speech is understandable to you? Some _____ Most _____ All _____

How much of his/her speech is understandable to others? Some _____ Most _____ All _____

Does he/she have any problems understanding what someone says? Yes _____ No _____

FAMILY HISTORY

Has SOMEONE IN THE CLIENT'S FAMILY (immediate household or extended family) had problems with any of the following:

	SPECIFY, if appropriate	PERSON'S RELATION TO CHILD (e.g., cousin, aunt, brother)	WHICH SIDE OF THE FAMILY? (Mother's side/ father's side?)
Learning Problems	Specify:		
Mental Retardation or Intellectual Disability			
Developmental Delay or Disability	Specify:		
Speech/ Language Problems			
Genetic Condition (e.g., Down's Syndrome, Fragile X)	Specify:		
Other conditions (e.g., Cerebral Palsy, Fetal Alcohol Syndrome)	Specify:		
ADHD or ADD			
Autism Spectrum Disorder/ PDD			
Tics or Involuntary Movements			
Depression			
Excessive Anxiety/Worry/Fears			
Obsessive-Compulsive Disorder			
Mania/ Bipolar			
Psychosis/Schizophrenia (e.g., sees or hears things not there, has unusual thoughts)			
Trouble with Law			
Alcohol/drug abuse			
Behavior problems as a child			
Seizure Disorder			
Chronic Illness			

BEHAVIOR/SOCIAL HISTORY OF CHILD/INDIVIDUAL

Has client experienced:	Yes	No	Specify or Describe:
Abuse (physical, verbal, or sexual)			
Neglect			
Parent Divorce			
Witnessed Domestic Violence			
Experienced Death of Close Relative or Friend			
Has Parent, Sibling, or other close relative with severe medical problems			
Had Traumatic Experience			
Excessive Shyness			
Excessive Worries/ Fears			
Overactivity			
Trouble Paying Attention			
Trouble with the Law			
Violence towards others, including physical fights			
Depression			
Suicidal Thoughts or Attempts			
Alcohol/Drug Use			
Trouble Making Friends			
Frequently Bullied by Others			
Bullies Others			
Aggression towards self or others			

Is she/he currently in counseling? _____ If so, what is the focus of treatment?_____

_____

Has she/he ever been in therapy? _____ If so, when?_____

What was the focus of treatment? _____

Has he/she ever been hospitalized or placed in residential treatment for mental health or behavioral problems?

If yes, when? _____ For how long? _____ Where?_____

Reasons/ Recommendations: _____

_____

Does he/she have outbursts or "meltdowns" due to anger, frustration, and or/ sensory overload? If so, are there strategies that you have used that are helpful in correcting his behavior? _____

_____

_____

On average, what are his/her grades this year? _____

In what classes does he/she do well? _____

In what classes does he/she struggle? _____

Has there been any big changes in his/her grades (for example, s/he was passing, now failing)? _____

If yes, describe (When did it start? What classes?): _____

_____

Does he/she enjoy and feel successful in school? _____ Please explain: _____

_____

Has the teacher told you that he/she is having difficulty? _____

If yes, is the problem related to learning or behavior? _____

Please describe teacher's concerns: _____

_____

_____

Did teachers in earlier grades have the same concerns? _____ Did they also have other concerns? _____

If yes, please describe: _____

_____

_____

Has/does your child receive tutoring? _____

_____

_____

What do you see as his/her strengths? _____

_____

_____

_____

Comments: (Please use other side if necessary): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Parent or Guardian signature Date

Parent or Guardian signature Date