



LEGACY CENTER

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INFO@LEGACYPARKER.COM - WWW.LEGACYPARKER.COM

Child's Demographic Information:

Last Name: _____ First Name: _____ MI: _____ Birthdate: _____ Gender: _____

Nickname: _____ Ethnicity (Optional): _____

Address: _____ City: _____ Zip: _____

Home Phone: _____

Mother's Cell: _____ Father's Cell: _____ Child's Cell: _____

List all phone #'s you authorize Legacy to leave messages on: _____

Who should be contacted to schedule appointments? _____

I authorize Legacy to send Newsletters and/or program updates via e-mail and/or mail: ____ Yes ____ No

Parent/Guardian Information:

Mother's Name: _____ Mother's Address: _____

Mother's Email: _____ Mother's Employer: _____

Father's Name: _____ Father's Address: _____

Father's Email: _____ Father's Employer: _____

Who is financially responsible for this child? _____

Primary Insurance Information:

Who is responsible for payments made to Legacy (Parent Name)? _____

Insurance Company Name: _____ ID #: _____ Group # _____

Policy Holder Name: _____ Policy Holder DOB: _____

Form filled out by: _____ Signature: _____ Date: _____

Attended Intake Session: _____ Date Intake Completed: _____

Referral Information:

Who referred you to Legacy Center? _____

Referring Provider's Profession (**circle**): Physician/Pediatrician Teacher Counselor Other: _____

Reason for the Referral? _____

Current Concerns (Main reasons for coming to Legacy):	LCCC Office Use Only
<p>Current Concern #1:</p> <p>When did the problem begin:</p> <p>What have you tried that has worked:</p> <p>What have you tried that has not worked:</p>	
<p>Current Concern #2:</p> <p>When did the problem begin:</p> <p>What have you tried that has worked:</p> <p>What have you tried that has not worked:</p>	
<p>Current Concern #3:</p> <p>When did the problem begin:</p> <p>What have you tried that has worked:</p> <p>What have you tried that has not worked:</p>	
<p>What are your primary goals for seeking treatment for your child?</p> <p>1.</p> <p>2.</p> <p>3.</p>	
<p>What is your child's understanding of why he/she is coming to Legacy?</p>	

Current Concerns (Main reasons for coming to Legacy) (continued):	LCCC Office Use Only
<p>Is your child experiencing any of the following?</p> <p> <input type="checkbox"/> Sad or depressed <input type="checkbox"/> Disorganization <input type="checkbox"/> Loss of interest <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Energy loss <input type="checkbox"/> Concentration Difficulties <input type="checkbox"/> Withdrawal <input type="checkbox"/> Constant Motion <input type="checkbox"/> Weight change <input type="checkbox"/> Impulsivity <input type="checkbox"/> Change in eating habits or appetite <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Too little sleep <input type="checkbox"/> Irritability <input type="checkbox"/> Too much sleep <input type="checkbox"/> Angry or mad <input type="checkbox"/> Worthlessness/Guilt <input type="checkbox"/> Restlessness <input type="checkbox"/> Suicidal plans <input type="checkbox"/> Behavior problems <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Nightmares <input type="checkbox"/> Verbal Aggression <input type="checkbox"/> Harm towards self <input type="checkbox"/> Physical Aggression <input type="checkbox"/> Defiance <input type="checkbox"/> Anxiety <input type="checkbox"/> Fearfulness <input type="checkbox"/> Meltdowns/Tantrums <input type="checkbox"/> Difficulty with changes in routine </p> <p>Anything else:</p>	

List all family members living in your child's home:				LCCC Office Use Only
Name:	Gender:	Age:	Relationship to CLIENT:	

Family Information:	LCCC Office Use Only
Maternal Education:	
Paternal Education:	
Primary language spoken in the home:	
Secondary language spoken in the home:	

Family Information (continued):	LCCC Office Use Only
<p>Are the biological parents of the client married? ____ Yes ____ No If NO, please provide co-parent consent form signed by both parents.</p> <p>What are the Legal Custody arrangements for your child?</p> <p>Who has medical care decision making for your child?</p> <p>Who has mental health care decision making for your child?</p>	
<p>Describe any current or previous family Child Protective Services involvement:</p>	
<p>Does your family currently have a caseworker? ____ Yes ____ No If yes, who? _____</p>	

Developmental History:	LCCC Office Use Only
<p>Did the biological mother receive prenatal care during the (check the box that applies):</p> <p>First Trimester: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Second Trimester: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Third Trimester: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Prescription Medications/ Over the counter drugs used by mom during pregnancy (specify trimester):</p>	
<p>Illicit drugs, marijuana, alcohol, and/or cigarette use during pregnancy (specify trimester, frequency, and amount):</p>	
<p>Medical Interventions during pregnancy:</p>	

Birth History:	LCCC Office Use Only
<p>Child's gestation: _____ Weeks</p>	
<p>Weight: _____ lbs. _____ oz.</p>	
<p>Medications used during child's labor/delivery: ____ Yes ____ No</p>	
<p>Type of delivery:</p>	
<p>Complications: ____ Yes ____ No If yes, please describe:</p>	
<p>Child's physical condition at birth:</p>	

Birth History (continued):	LCCC Office Use Only
Was the child admitted to the NICU? ____ Yes ____ No If yes, please describe interventions: If yes, how long was your child in the NICU?	

Developmental Skill:	Age Acquired	Concerns	LCCC Office Use Only
Sat alone			
Crawled			
Stood alone			
Walked alone			
Does your child ever walk on his/her toes? Yes ____ No ____			
Said single word What was 1 st word?			
Said 2-3 word sentences			
Toilet training	Day: Night:		
Fine Motor Skills (Pincer grasp, pencil grasp, etc.)			
Eye contact			
Responded to smile			
Parallel play (Played same activity side by side)			
Interactive play (Play that involves sharing and turn taking)			
Identified a best friend			

Medical History:	LCCC Office Use Only
Describe any significant past/current illnesses:	
Describe any significant past/current surgeries:	
Describe any significant past/current allergies:	
Does your child have an autoimmune deficiency? If so, please describe:	
Describe any past hospitalizations:	
Describe any past psychiatric hospitalizations:	
Describe any significant past/current head injuries/concussions: Did your child lose consciousness? ____ Yes ____ No If yes, for how long? _____ Did you seek medical attention for your child? ____ Yes ____ No What other symptoms did your child experience?	
Describe any accidents/trauma:	
Describe any environmental trauma your child may have experienced (e.g., tornados, floods, hurricanes, etc.):	
Describe any sexual/physical/mental abuse:	
Describe any concerns regarding your child's vision: Date of most recent vision exam: _____	
Is your child color blind? If yes, please explain:	
Describe any concerns regarding your child's hearing: Date of most recent hearing exam: _____	

Medical History (continued):	LCCC Office Use Only
<p>Describe your child's sleep patterns?</p> <p>Where does your child sleep? _____</p> <p>Does your child have difficulty falling asleep? ____ Yes ____ No If yes, please describe:</p> <p>Does your child have difficulty staying asleep? ____ Yes ____ No If yes, please describe:</p> <p>Does your child snore? ____ Yes ____ No If yes, please describe:</p>	
<p>Describe your child's appetite?</p>	

Child's Prescribing Physician:	LCCC Office Use Only
<p>Physician's Name: _____</p> <p>Physician's Phone: _____</p> <p>Physician's Address: _____</p>	

Medication History:						LCCC Office Use Only
Prescribed Medication	Purpose of Medication	Dose	Date Began	Date Ended	Response to the medication and why it ended?	

Medication History (continued):					
Holistic or Homeopathic Medications	Purpose of Medication	Dose	Date Began	Date Ended	Response and why it ended?

Family Medical History:	LCCC Office Use Only
List any learning/educational problems in your child's family history: _____ Immediate/Extended _____ Immediate/Extended _____ Immediate/Extended	
List any mental health problems in your child's family history: _____ Immediate/Extended _____ Immediate/Extended _____ Immediate/Extended	
List any drug or alcohol problems in your child's family history: _____ Immediate/Extended _____ Immediate/Extended _____ Immediate/Extended	

Therapy / Treatment History:			LCCC Office Use Only
Treatment Provider	Type of Service (Speech therapy, occupational therapy, physical therapy, vision therapy, etc.)	Approximate Dates of Services	
Has your child been diagnosed with a mental health diagnosis? ____ Yes ____ No If yes, what diagnosis was given? What provider gave the diagnosis?			
Has anyone (besides the current referring provider) ever recommended that your child receive an evaluation or assessment? ____ Yes ____ No If yes, who? Why was a recommendation made for an evaluation?			

Therapy / Treatment History (continued):	
<p>Has your child ever received counseling in the past? ____Yes ____No If yes, who was the treating provider?</p> <p>What diagnosis was your child being treated for?</p> <p>What were the goals in treatment?</p> <p>How do you feel your child responded to the counseling services provided?</p> <p>Were any further recommendations made by the treating provider? If yes, what were they?</p>	
<p>Has your child had previous testing? (Tutoring center, school, child find or early intervention)? ____Yes ____No _____ Date of Evaluation If yes, please provide Legacy Center with copies of previous evaluations.</p> <p>If yes, please described the type of testing your child received:</p> <p>Did your child receive a diagnosis? ____Yes ____No If yes, what diagnosis was given:</p> <p>What recommendations were made as a result of the evaluation?</p>	
<p>Is your child currently receiving any alternative therapies? (Acupuncture, homeopathic, herbal, biofeedback, etc.)? ____Yes ____No If yes, please explain:</p>	
<p>Has your child received genetic testing to assess for chromosomal abnormalities? ____Yes ____No If yes, what were the results?</p> <p>If no, has genetic testing ever been recommended? If yes, why?</p>	

Sensory History:	LCCC Office Use Only
<p>Is your child sensitive to sights, sounds, textures, flavors, smells, or other sensory input? ____Yes ____No If yes, please describe:</p>	
<p>Does your child appear highly interested in sights, sounds, textures, flavors, smells, or other sensory input? ____Yes ____No If yes, please describe:</p>	
<p>Does your child appear clumsy or uncoordinated? ____Yes ____No</p>	
<p>Would you describe your child as a picky eater? ____Yes ____No</p>	
<p>Please list any other sensory concerns:</p>	

Behavior History:				LCCC Office Use Only
Concerning Behavior	Age Began-Age Ended	Severity on a scale of 1-10 (10 being worst)	If known, triggers of behavior problem (people, events, etc)	

Behavior History (continued):	LCCC Office Use Only
Please describe your child's typical mood:	
Please describe your child's personal strengths:	
Please list any of your child's extracurricular activities:	
Does your child repeatedly say any words over and over? ____Yes ____No	
Does your child display any repetitive behaviors? ____Yes ____No (e.g., spinning, turning off and on lights, lining up toys, stacking objects, etc.) If yes, describe:	
Has your child ever had an ability or skill and then lost it? ____Yes ____No If yes, please indicate what skill(s) your child lost and for how long:	
Does your child have any restricted interests (an interest that is all encompassing or unusual in its intensity)? ____Yes ____No If yes, please describe:	
Do you have concerns about your child's coping skills? If yes, please describe: What coping skills does your child use when upset?	
Does your child use any alcohol and/or illicit drugs? ____Yes ____No If yes, please describe:	
Has your child had any legal or criminal issues or involvement with law enforcement authorities? ____Yes ____No If yes, please describe issues and date(s) of involvement:	

Discipline History:				LCCC Office Use Only
Method:	Frequency:	Consistency among caregivers?	Effectiveness	

Social History:	LCCC Office Use Only
Are there any concerns about your child's ability to form/maintain friendships? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:	
Are there any concerns about your child's social skills? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:	
Who does your child prefer to spend time with?	

School History:				LCCC Office Use Only
Name of School	Grades Attended (in years)	Child's Behavior	Academic of Special Services Received	
Current School:	Current Grade:			

Does your child like school? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please describe:	
Has your child ever repeated or skipped a grade? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which grade?	

School History (continued):	
How does your child respond to redirection for behavior at school?	
Has your child had any suspensions or detentions? ____ Yes ____ No If yes, please describe:	
Does your child have a current or past: IEP (Individualized Education Program)? ____ Yes ____ No Date of most recent plan: _____ ILP (Individualized Learning Program)? ____ Yes ____ No Date of most recent plan: _____ RTI (Response to Intervention)? ____ Yes ____ No Date of most recent plan: _____ 504? ____ Yes ____ No Date of most recent plan: _____	
If you answered YES to any of the questions above, please describe the type(s) of services your child receives:	

Please indicate any other concerns you may have about your child that you feel would important for your provider to know:
