

Client Name: _____



Centers For Motivation, Inc.

Psychological Testing Services

INTAKE QUESTIONNAIRE

Child's Name _____	Date _____
Child's DOB _____	
Gender _____	Father's Name _____
	Mother's Name _____
Address _____	
City _____	
State _____	
Zip _____	Handedness <input type="checkbox"/> Right
Phone _____	<input type="checkbox"/> Left
E-mail _____	<input type="checkbox"/> Ambidextrous

Current School Contact Information

School Name _____	Grade _____
School Address _____	Contact Person _____
Phone _____	Position _____

Child's strengths:

<input type="checkbox"/> creative	<input type="checkbox"/> positive attitude
<input type="checkbox"/> artistic	<input type="checkbox"/> friendly
<input type="checkbox"/> athletic	<input type="checkbox"/> leader
<input type="checkbox"/> entrepreneurial	<input type="checkbox"/> enjoys reading
<input type="checkbox"/> street-wise	<input type="checkbox"/> enjoys writing
<input type="checkbox"/> common sense	<input type="checkbox"/> active in community
<input type="checkbox"/> outgoing	<input type="checkbox"/> team sports
<input type="checkbox"/> intelligent	<input type="checkbox"/> active in school activities
<input type="checkbox"/> musical talent	<input type="checkbox"/> physically fit
<input type="checkbox"/> positive interactions with family	<input type="checkbox"/> confident
<input type="checkbox"/> positive interactions with peers	<input type="checkbox"/> humorous
<input type="checkbox"/> independent	<input type="checkbox"/> academic acheiver
<input type="checkbox"/> self-directed	<input type="checkbox"/> orderly
<input type="checkbox"/> emotionally stable	<input type="checkbox"/> helpful
<input type="checkbox"/> hobbies/interests (list):	

Does the child suffer from any of the following?

<input type="checkbox"/> depression	<input type="checkbox"/> attention difficulty
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Client Name:

- anxiety
- stress/trauma
- eating problems
- thought problems

- behavior problems
- memory problems
- academic problems

Please describe:

Current general medical conditions (check all that apply):

- hypertension
- heart disease
- cardiac (other)
- asthma
- HIV
- allergies (if yes, explain below)
- hypothyroidism
- other significant systemic illness (specify)

- diabetes
- endocrine (other)
- cancer
- seizure disorder
- stroke
- neurological (other)
- chronic lung disorder

Additional comments:

Has there been a history of any of the following:

- head injury
- illness
- surgery
- anesthetics

- high fever
- loss of consciousness
- poisoning
- personality changes

Details:

Does the child take any medications regularly?

Medication	Dosage	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's Home Situation:

- Parents married
- Parents divorced
- Foster care
- One or more parent deceased
- Living with relative other than parent(s):
- Residential placement
- Other (specify)

(how long)
(date)

(specify)

How did you hear about the *Centers For Motivation, Inc.*?

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Has the client had any previous psychological testing/assessments?

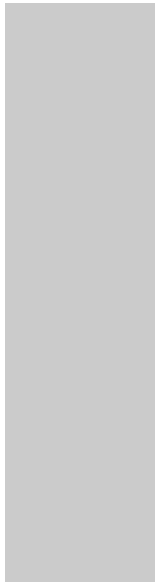
Test	Reason	Administrator	Date
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Other pertinent information

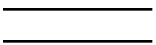
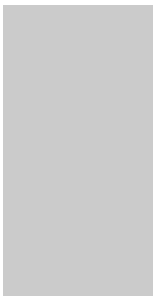
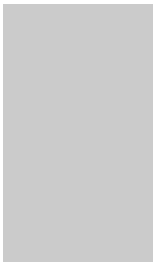
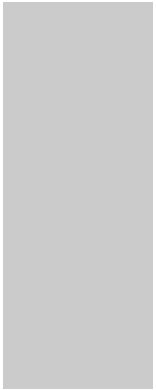
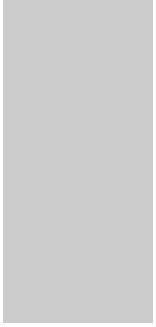
Comments:

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