denver integrative assessment

Instructions: Please fill out this information to the best of your ability and bring the completed form with you to your first appointment.

Child's Name: _____ DOB:_____

Gender/Gender Preference/Preferred Pronouns:_____

Cultural/Ethnic/Racial/Religious Identity:_____

Person completing this form (name and relationship to child): _____

_____

Address: _____

_____

Phone: Home: _____ Work/Cell_____

Email Address: _____

Child lives with:

Name	Age	Relationship	Occupation/School Grade

Are any brothers or sisters of this child not living with him/her? ☐ Yes ☐ No
If so, please give same information as above.

_____

Parents' place(s) of employment: _____

_____

Child's Physician: _____

Who referred you? _____

Purpose of consultation (brief summary of your main questions/concerns): _____

_____

_____

_____

FAMILY HISTORY

Was either parent married before? ☐ Yes ☐ No
If so, please list which parent and the dates of the marriage and separation and/or divorce:

_____

_____

_____

Does either parent have a child or children born prior to this marriage? If so, please list:

Name	Age	Place of Residence

_____

_____

_____

_____

If this is a step-family, what contact does this child have with the natural parent with whom he/she is not living? _____

_____

If the child lives with two parents, have the parents ever separated for more than a week? ☐ Yes ☐ No

If so, when?_____

Has this child ever been separated from his/her family? _____ Age of child? _____

Duration, Reason: _____

How would you describe this child's relationship with each parent?

_____

_____

_____

How would you describe this child's relationship with his/her brothers and sisters?

_____

_____

Please indicate whether there are any relatives of this child, including parents, siblings, grandparents, aunts, uncles, or cousins, who have had any serious chronic or recurrent illnesses or abnormalities such as genetic abnormalities, developmental disorders, seizure disorders, mental health diagnoses, intellectual disabilities, school problems, learning disabilities, attention disorders (ADHD), cerebral palsy, deafness or blindness.

Relationship to Child	Age	Diagnosis/Problem

_____

_____

_____

_____

Parents' work history during this child's life: Periods of unemployment, work evenings or long hours? Frequent job changes and/or moves? Attending school?

_____

_____

_____

Is there any history among the parents of this child of excessive use of alcohol or drugs, prescription or other?

_____

In addition to what you have already indicated, what events such as deaths, illnesses, accidents or separations have there been among family or close friends?

_____

_____

Has either parent been involved in any legal difficulties? _____

_____

PREGNANCY HISTORY (if known)

What was the health and emotional status of the child's mother during her pregnancy?

_____

Did the mother smoke? ☐ Yes ☐ No If yes, approximate packs/day _____

Drink alcoholic beverages? ☐ Yes ☐ No If yes, approximate drinks/day_____

Recreational drug use? ☐ Yes ☐ No If yes, which drugs and how often? _____

_____

Please list all medications, prescription or otherwise taken during pregnancy:

Medication Name _____ Condition prescribed for _____

Medication Name _____ Condition prescribed for _____

Medication Name _____ Condition prescribed for _____

Medication Name _____ Condition prescribed for _____

Medication Name _____ Condition prescribed for _____

Were there any illnesses during pregnancy? _____

Were there any unusual features of the pregnancy? _____

BIRTH HISTORY (if known)

Birth weight: _____ Type of delivery: _____

Gestational Age: _____ Baby's condition at birth: _____

Did baby require oxygen? ☐ Yes ☐ No

Any problems during the first week? (incubator, jaundice, feeding difficulties? ☐ Yes ☐ No

If yes, please describe: _____

Sleep patterns/problems: _____

Temperament/Personality: _____

Developmental Milestones:

Milestone	**Approximate Age**
Rolled Over	
Sat without Support	
Crawled	
Slept through the Night	
Walked Independently	
Spoke Understandable Words	
Spoke Understandable Sentences	
Toilet Trained (Day)	
Toilet Trained (Night)	
Read Written Words	
Tied Shoelaces	

Sensory Sensitivity/Reactivity/Intolerance:

Touch (clothing tags/seams, stickiness, food textures, physical touch, hot/cold):

_____

Sounds (loud noises, specific noises):_____

Smells: _____

Tastes (spices, etc.):_____

Lightness/Darkness:_____

Compared to his/her peers, please rate how coordinated your child is at the following activities:

Activity/Coordination Level	Poor	Below Average	Average	Above Average
Walking				
Running				
Riding a two-wheel bicycle				
Throwing a ball				
Catching a ball				
Using a fork and knife				
Handwriting				

MEDICAL HISTORY

If the child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (describe any complications):_____

_____

Operations:_____

Hospitalizations for illness(es) other than operations:_____

_____

History of traumatic brain injury/concussion (please indicate whether loss of consciousness (and if so, for how long) and/or hospitalization was involved):

_____

_____

Seizures: ☐ Yes ☐ No Age: _____With fever? ☐ Yes ☐ No Age: _____

Meningitis or encephalitis ☐ Yes ☐ No Age: _____

Persistent high fevers: ☐ Yes ☐ No Highest temperature recorded:_____

Eye problems: ☐ Yes ☐ No If yes, please explain: _____

Ear Problems: ☐ Yes ☐ No If yes, please explain: _____

PRESENT MEDICAL STATUS

Present illness(es) or symptoms which are being treated: _____

_____

Child's Currently Prescribed Medications:

Medication Name _____ Condition prescribed for _____

Medication Name _____ Condition prescribed for _____

Medication Name _____ Condition prescribed for _____

Medication Name _____ Condition prescribed for _____

SCHOOL HISTORY

Name of present school: _____ Phone:_____

Address: _____ Grade:_____

Please list all schools attended, including pre-school, and approximate dates.

_____

_____

Describe any special programming he/she may have had such as speech therapy, occupational therapy, physical therapy, remedial classes, special tutoring, special education, repeating a grade, counseling, or psychological services. Please indicate age of child and duration of service.

_____

_____

_____

Present school performance (e.g., above average, good, fair, poor): _____

Please describe any school problems you are aware of: _____

_____

ADAPTIVE BEHAVIOR

Please give a detailed description of the child's "average" weekday: _____

_____

_____

_____

Sleep Schedule: _____

What activities does your child enjoy? _____

_____

Approximately how much time does your child spend in front of a screen each day? _____

What jobs or responsibilities does your child have at home? _____

_____

How reliably does your child perform them? _____

Does your child get an allowance? ☐ Yes ☐ No

Is it dependent on chore completion? ☐ Yes ☐ No

Has your child ever held a job? ☐ Yes ☐ No

Job Title: _____ Dates: _____

How do you discipline your child? _____

How does the other parent discipline? _____

What behaviors require disciplining? _____

_____

Has your child ever been involved in thefts, vandalism, curfew violations, drug or alcohol usage, or other legal difficulties?_____

_____

What do you think are your child's strong points, (i.e. what does he/she do well, what do you like best)?

_____

_____

What do you think are your child's weaknesses, (i.e. challenges, personality characteristics, etc.)?

_____

_____

Have you ever sought psychological or counseling services for your child before? If so, for what, with whom, and at what age?

_____

_____

Has your child participated in a psychological or educational evaluation? ☐ Yes* ☐ No

Clinician Name: _____ Date of Evaluation: _____

Clinician Name: _____ Date of Evaluation: _____
*Please bring copies of all prior evaluation reports with you to the initial appointment

Is there any other information that you think it would be helpful for me to have?

_____

_____

_____

_____