# Childhood Solutions, PC

Building a strong future for children, adolescents and their families

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## Interval History

**Date: ____/____/____**

| Background Information |
|---|
| Name: _____ Sex: M or F DOB:____/____/____ |
| Address: _____ |
| City: _____ State: _____ Zip: _____ |
| Phone: _____ Cell: _____ |
| Person completing form: _____ Relationship to child: _____ |

| |
|---|
| **Child's Doctor:** _____ |
| Address: _____ |
| City: _____ State: _____ Zip: _____ Phone: _____ |
| |
| Who referred child for evaluation/consultation:_____ _____ |

| |
|---|
| **What are your concerns or questions about your child?** _____ _____ _____ |
| When did you first become concerned? _____ |
| What caused you to become concerned?_____ _____ |

**455 Pennsylvania Avenue ■ Suite 115 ■ Fort Washington ■ PA ■ 19034 ■ Tel: 215.653.0363 ■ Fax: 215.653.0361**

What would you like to accomplish during this evaluation or therapy? _____

_____

Please list any medications child takes on a regular basis:_____

_____

**Behavioral History**

How would you describe your child's current personality: _____

_____

_____

How does your child get along with other children: _____

_____

_____

What does your child like to do for play: _____

_____

_____

Does your child have difficulty with any of the following (circle all that apply):

*Sleeping Eating Tantrums Head banging Hitting Biting Lying Stealing*

*Mouthing or eating non-food items Impulsive Hyperactive Short attention span*

*Forgetful Aggressive Destructive Toileting Other:* _____

How do you handle these behaviors: _____

_____

_____

| **Educational History**<br><br>Please list your child's current school or early intervention program | | |
|---|---|---|
| **Child's Age** | **School** | **Grade or Type of Service** |
| | | |
| | | |
| Does your child have difficulties in school or receive any tutoring or extra support? If yes, please explain:<br><br>_____<br><br>_____ | | |

| **Previous Evaluations**<br><br>**Please list all previous evaluations your child has had since the last appointment** | | |
|---|---|---|
| Date | Type of Professional | Results |
| | | |
| | | |
| | | |

**The following statements MUST be signed by ALL patients, age 14 and over. If patient is under 14, parent must sign**

My signature below indicates that I have read and understood the office policies of Childhood Solutions, PC. I also understand that failure to pay for any services rendered can result in legal action.

Signature _____ Relationship to patient_____ Date ____/____/____

I give my consent to Childhood Solutions, PC to evaluate and/or treat myself or my child under 14 years of age.

Signature _____ Relationship to patient_____ Date ____/____/____

Please tell us anything else you think may be important for us to know: _____