Rigby Psychological Services, PLLC
2505 S. 17th St, Suite 200
Wilmington, NC 28401
(910) 254-4545

Dear Parent(s)/Guardian(s):

I am excited to be working with you and your child soon. Enclosed are several forms that need to be completed *prior* to your child's initial appointment.

The following forms are included within this packet:

1. Background History Form
2. Billing/Insurance Paperwork
3. What to Expect: Preparing For Your Child's First Visit

Please **complete and return** these forms to the following address ***as soon as possible***:

Attention: Intake
Potentials
2505 S. 17th St, Suite 200
Wilmington, NC 28401

If any questions or concerns arise as you complete these forms, please to call my office staff at **910-254-4545**.

I look forward to seeing you soon!

Intake Packet for Assessment Clients

Background Information Form

The purpose of this questionnaire is to gather information about your child and family before the intake appointment. Your answers will allow Dr. Rigby to plan the assessment specifically for your child. Do not worry if you do not have all of the information to answer every question, as we will be discussing this further at the intake appointment. Your time and effort in completing this questionnaire is greatly appreciated!

General Information

Date: __________ Form Completed By: _____________________ Relationship to Child: ____________

Child's Name: ____
(First) (Middle) (Last) ("Nick Name")

Date of Birth: ________________ Sex: _______________________ Grade: _____________________

Name of School: _____________________________ School District: ___________________________

Mother's Name: ____________________________ Father's Name: ____________________________

Address: __________________________________ Address: ___________________________________

Best Phone # ______________________________ Best Phone # ______________________________

Occupation ________________________________ Occupation _________________________________

Highest Grade Completed _____________________ Highest Grade Completed _____________________

Best email address to contact you____.

Does your child have other parent(s)/stepparent(s)/primary caregivers? □ Yes □ No

If yes, please provide the following information:

Name: ____________________________________ Name: _____________________________________

Address: __________________________________ Address: ___________________________________

Phone # __________________________________ Phone # ___________________________________

Relationship to this child: ____________________ Relationship to this child: _____________________

Occupation ________________________________ Occupation _________________________________

Highest Grade Completed _____________________ Highest Grade Completed _____________________

Is your child adopted? □ Yes □ No

With what adult(s) does this child live? ____

At what age did the child come into the current living situation? _____________________________________

Please list ALL brothers and sisters, AND any other children living in the home with the client.

Age	Sex	Relationship to this Child	Living at home?
_____	_____	________________________________	______________________________
_____	_____	________________________________	______________________________
_____	_____	________________________________	______________________________
_____	_____	________________________________	______________________________
_____	_____	________________________________	______________________________

How does your child relate to (or "get along" with) other family members? ______________________________

____

Language(s) other than English spoken in home: ____

Have there been any recent changes or stresses in the family/home? □ Yes □ No

If yes, please describe: ____

Pregnancy and Birth History

Number of Pregnancies of the child's biological mother? ____

During the pregnancy with the child, was/did the mother:

	Yes	No	Further Description
Under a doctor's care?	□	□	______________________
Experience infection or other illness?	□	□	______________________
Have toxemia?	□	□	______________________
Have bleeding?	□	□	______________________
Have unusual physical strain or injury?	□	□	______________________
Have unusual emotional strain?	□	□	______________________
Drink alcoholic beverages? (please indicate how much)	□	□	______________________
Smoke cigarettes? (please indicate how much)	□	□	______________________
Take medications or drugs? (other than vitamins/iron)	□	□	______________________
Other complications?	□	□	______________________

Estimated length of pregnancy: _______ (weeks)

Type of labor onset: □ Induced □ Spontaneous

Length of Labor:_____________________

Type of delivery: □ Vaginal □ Cesarean

Type of anesthesia: □ Gas □ Spinal □ None

Baby's Presentation: □ Breech □ Head

Did any complications occur during delivery? □ Yes □ No

If yes, please check if any of the following occurred:

□ Toxemia/Pre-eclampsia □ Maternal Fever □ Fetal Distress □ Medications Used: _____________

In addition, were any specialized procedures used (e.g., forceps, suction) during delivery? □ Yes □ No

If yes, please state: ____

Birth weight: _______ lbs _______oz Apgar Scores, if known: _____ 1 min _____ 5 min _____10 min

What was the baby' condition following delivery? ____

Please describe any specialized treatment provided to baby following delivery: ___________________________

____

What was the mother's condition following delivery? ____

Length of hospital stay following delivery: __________ Mother __________ Baby

Check any of the following which occurred during your baby's first month of life:

□ Breathing Problems □ Convulsions □ Skin Rash □ Excessive Vomiting □ Injury

□ Jaundice (yellow) □ Infection □ Birth Defect □ Excessive Crying □ Feeding Difficulty

Health and Medical History

Who is your child's primary care physician? ____

Has your child had any of the following:

	Yes	No	During What Ages? (e.g., 3 months to 2 years)
Convulsions, seizures, fainting spells	□	□	__________________________
Vision or eye problems	□	□	__________________________
Ear Infections	□	□	
If yes, approximately how many ear infections has your child had? _______			__________________________
Have PE tubes been inserted?	□	□	__________________________
If yes, more than once? _____ How many times? _____			
Hearing problems	□	□	__________________________
Allergies	□	□	__________________________

If yes, what is your child allergic to? ____

	Yes	No	During What Ages?
Any serious accidents or injuries?	□	□	__________________________
Any poisoning or overdose?	□	□	__________________________
Any problems with weight gain or loss?	□	□	__________________________
Any surgeries or overnight hospitalization?	□	□	__________________________

If yes, what surgeries or procedures and why? ____

	Yes	No	During What Ages? (e.g., 3 months to 2 years)
Any other chronic or serious health problems?	□	□	___
Any history of lead poisoning or other toxin exposure?	□	□	___
Any severe reaction to an immunization?	□	□	___
Had a medical check-up within the last 12 months?	□	□	___

If any health problems or recommendations, what/by whom? ___

What medications is your child currently taking? ___

Has your child ever been given a diagnosis (e.g., ADHD)?	□	□	___

If so, please state diagnosis? ___

Developmental History

Please comment on when your child did the following things:

Action	Time (please circle)	Approximate Age (in months)
Roll over (tummy to back)	seemed early / seemed on time / seemed late	___
Roll over (back to tummy)	seemed early / seemed on time / seemed late	___
Sit up with support	seemed early / seemed on time / seemed late	___
Sit up without support	seemed early / seemed on time / seemed late	___
Crawl	seemed early / seemed on time / seemed late	___
Pull up to stand on furniture	seemed early / seemed on time / seemed late	___
Walk alone	seemed early / seemed on time / seemed late	___
Give up his/her bottle	seemed early / seemed on time / seemed late	___
Drink from sipper top cup	seemed early / seemed on time / seemed late	___
Drink from regular cup	seemed early / seemed on time / seemed late	___
Finger feed self	seemed early / seemed on time / seemed late	___
Feed self with a spoon	seemed early / seemed on time / seemed late	___
Dress Self	seemed early / seemed on time / seemed late	___
Undress Self	seemed early / seemed on time / seemed late	___
Achieve toilet training for bladder	seemed early / seemed on time / seemed late	___
Achieve toilet training for bowels	seemed early / seemed on time / seemed late	___
Smile	seemed early / seemed on time / seemed late	___
Coo	seemed early / seemed on time / seemed late	___
Babble (da-da-da, ba-ba-ba)	seemed early / seemed on time / seemed late	___
Jargon (talk in own special language)	seemed early / seemed on time / seemed late	___
Say single words	seemed early / seemed on time / seemed late	___

Begin to use phrases (e.g., "more juice") seemed early / seemed on time / seemed late ______________

Begin to use short sentences seemed early / seemed on time / seemed late ______________

School History

What schools has your child attended? (please list in chronological order beginning with nursery/preschool)

____

____

What are your child's academic strengths? ____

□ Reading phonics/decoding □ Reading Comprehension □ Math □ Written Work

□ Study Skills □ Organizational □ Listening/Understanding Oral Directions/Directions □ Other

In what areas does your child have more difficulty? ____

□ Reading phonics/decoding □ Reading Comprehension □ Math □ Written Work

□ Study Skills □ Organizational □ Listening/Understanding Oral Directions/Questions □ Other

Are you worried when you compare your child to other child his/her age academically? □ Yes □ No

If yes, please describe ____

Does your child like to attend school? □ Yes □ No

Has your child ever repeated a grade? □ Yes □ No Which? ________ Reason? ____________

Does your child receive extra school help? □ Yes □ No

If yes, please check which kind: □ Tutoring □ Counseling □ Other (List) ____________

Has your child had learning problems: □ In preschool or kindergarten? □ In elementary school? □ In middle school? □ In high school?

Has/did your child ever receive special education services? □ Yes □ No

If yes, why were these services initiated (e.g., speech, reading difficulty)? ______________________________

If yes, when did he/she first begin receiving special education services? _____________

If yes, what services does/did he/she receive? ____

If services have been discontinued, when did this occur? _____________

Social and Behavioral History

Are you worried when you compare your child socially to other children his/her age? □ Yes □ No

If yes, please describe ____

How easily does your child make friends? □ Worse than average □ Average □ Better than average

Who does your child get along with best? □ Older children □ Same-age children □ Younger children

How many *close* friends does your child have? ___________________

Does your child have a best friend? □ Yes □ No

If yes, how old is he/she? _____ How long have they been friends? _____

What are your child's main hobbies or interests? ____

Please list the things your child does well: ____

____

What are the most positive features about your child? __________________________________

____

Are there behavior problems at school? □ Yes □ No

If yes, please describe ___________________________________

Are there behavior problems at home? □ Yes □ No

If yes, please describe ___________________________________

Family Medical, Emotional, and Learning History

Biological mother's age and general health: ______________________

Biological father's age and general health: ______________________

Please check to indicate if any of the child's *biological* family members have had the following conditions:

	Immediate Family			**Father's Relatives**			**Mother's Relatives**		
Condition	**Dad**	**Mom**	**Sib**	**Dad**	**Mom**	**Sib**	**Dad**	**Mom**	**Sib**
Down Syndrome									
Autism									
Mental Retardation									
Learning Difficulties									
Reading									
Written Language									
Mathematics									
Oral Language									
Hydrocephalus									
Language/Speech Delay									
Hyperactivity									
Attention Deficit									
Conduct Problems									
Drug/Alcohol Abuse									
Neurological Disorders (Please specify)									
Epilepsy/Seizures									

Condition	Immediate Family			Father's Relatives			Mother's Relatives		
	Dad	Mom	Sib	Dad	Mom	Sib	Dad	Mom	Sib
Tics									
Depression									
Anxiety									
Panic Attacks									
Obsessive-Compulsive Disorder (OCD)									
Diabetes or Hypoglycemia									
Hearing Loss									
Vision Problems									
Held back in school									
Muscular problems/weakness									
Other: ____________________									

Reason(s) for Current Appointment

Who recommended or referred your child for this appointment? ______________________________________

What questions or concerns would you like addressed/answered? _____________________________________

____

____

____

What do you feel led to/caused these concerns? ____

____

When did you first notice these concerns? ____

Additional Comments (If needed, please use the backside of this page.)

____

____

____

____

____

____

____

____

Child's Name _________________________ *Child's DOB* ____________________________

What to Expect for a Psychological Evaluation/Testing Appointment

When your child has been scheduled for an evaluation appointment, here are a few suggestions to help make the experience a more positive one.

1. It has been helpful for many parents to explain the visit as a "Learning Check-Up".
2. Tell a younger child that he or she will be doing "learning activities" like listening, solving puzzles, and reading. Please do *not* set the expectation that your child is coming to *play games*. Although many children do enjoy "showing off" what they have learned, your child will be taking challenging tests and over-selling the appointment as a "fun" thing may prove counter-productive.
3. Tell a younger child that this is *not* a physician appointment; no one will use needles, etc.
4. For an older child who expresses concern over the stigma of an evaluation or fear that having this assessment means that he or she is "stupid", "crazy", or "mental", you may wish to reassure him/her that everyone deals with periodic challenges. Coming in for an evaluation does not mean he or she has done anything wrong; rather, this appointment is an opportunity to find out his or her strengths and weaknesses and perhaps identify some new ways of dealing with things to make home, school, and/or social life go more smoothly.
5. If your child's appointment is longer than two hours, it will probably be helpful to bring a snack and a drink.
6. If your child's appointment is scheduled to last four or more hours, an hour break will be scheduled for lunch.
7. Tell your child that it is "OK" if he or she doesn't know everything.
8. Parents' undivided attention is needed during the separate *feedback session*. It is generally considered best not to have your child in attendance during that time (the exception would be a college-bound high school senior or college-age student).
9. High school age clients are encouraged to attend an additional, separate feedback session for approximately 20 minutes during after school hours following the parent feedback appointment. The purpose of this session is to broadly go over the major findings (e.g., talk about strengths and weaknesses, not specifics, like IQ score) and, if appropriate, to explain why a diagnosis was made or certain recommendations given. ***PLEASE MAIL COPIES OF ANY PAST EVALUATION REPORTS, STANDARDIZED TEST SCORES, AND REPORT CARDS BEFORE THE APPOINTMENT, IF POSSIBLE.***
10. Every effort is made to get you the complete evaluation report as quickly as possible; however, given the length and detail of reports for full evaluations, **it can take *up to 4 weeks* from the date of the feedback appointment for you to receive the dictated report in the mail**. For time sensitive matters, the psychologist can provide brief/ summary letters to physicians, schools, etc. in advance of the full report to facilitate interventions or placement decisions. Please inform the psychologist of these sorts of time-sensitive needs as soon in the process as you are aware of them.