Dear Parent:

Thank you for your interest in Parent-Child Interaction Therapy services at the Mailman Center for Child Development at the University of Miami, Miller School of Medicine. In order for us to best help your child, we ask that you complete the enclosed form. This form will ask you some questions about your child that you are seeking services for. Answering these questions will help us better understand the concerns you have about your child and help us determine whether Parent-Child Interaction Therapy would be a good fit for your family’s needs. Once we receive your completed form, we will contact you regarding your status within two business days and to schedule an appointment. If it is decided that another service or facility would be more helpful for your child, we will provide you with that referral information. Please be sure to add the proper postage to prevent any delays. You can fax completed forms to 305-243-4512 or email them to PCIT@med.miami.edu. If you have any questions please call at (305) 243-0234. We look forward to speaking with you.

Thank you,

Jason Jent, Ph.D.
Psychology Director
Assistant Professor of Clinical Pediatrics
Division of Clinical Psychology
Department of Pediatrics
University of Miami Miller School of Medicine

Allison Weinstein, Ph.D.
PCIT Associate Director
Division of Clinical Psychology
Department of Pediatrics
University of Miami Miller School of Medicine
PCIT
BACKGROUND/DEMOGRAPHIC INFORMATION

Child’s Name: ________________________________  Gender:  M /  F  DOB: ________________________________

Parent(s) / Primary Caregiver(s) ________________________________________________________________

________________________________________________________________________________________

Phone Number(s) __________________________________________________________

Address __________________________________________________________________________________

________________________________________________________________________________________

How many people (adults and children) reside in your household? __________________

What is your yearly total household income? _________________________________

Which of the following best describe your family’s ethnic background?

1) ______ Afro-American (Black)
2) ______ Latin-American (specify) ______________________
3) ______ English, Scottish, or Welsh
4) ______ German
5) ______ Irish
6) ______ Asian
7) ______ Polish
8) ______ French
9) ______ Italian
10) ______ Spanish
11) ______ Scandinavian (Swedish, Danish, Norwegian, or Finnish)
12) ______ Other (specify) ______________________

Involvement with Child Protective Services

Have you or any of the child’s primary caregivers ever been involved with child protective services (e.g., the Department of Children and Families – DCF, etc.)  ☐ YES  ☐ NO

If yes, please explain:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
# Background Information

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>DOB:</th>
</tr>
</thead>
</table>

## Primary Presenting Concerns

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What concerns do you have about your child?</td>
<td></td>
</tr>
<tr>
<td>What (if any) concerns do you have about your child’s behavior or emotions?</td>
<td></td>
</tr>
<tr>
<td>What (if any) concerns do you have about your child’s speech and language functioning?</td>
<td></td>
</tr>
<tr>
<td>What (if any) concerns do you have about your child’s learning or academic performance?</td>
<td></td>
</tr>
<tr>
<td>What (if any) concerns do you have about your child’s development?</td>
<td></td>
</tr>
<tr>
<td>Has your child been diagnosed with any medical, psychological, or genetic conditions?</td>
<td></td>
</tr>
<tr>
<td>Has your child received any previous testing or evaluations?</td>
<td></td>
</tr>
</tbody>
</table>

If yes, please indicate your child’s diagnosis, the date of diagnosis, and what type of professional provided the diagnosis.

Please describe and attach results of testing/evaluations.
### Child Developmental Concerns

**Please answer the following questions about your child:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child prefer to play alone rather than with other people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child avoid eye contact with people?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child appear overly sensitive to noises?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child appear overly sensitive to certain tastes or textures?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child produce unusual vocal noises?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child have a history of speech delay?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child engage in head-banging or other self-injurious behavior?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child engage in hand or finger flapping?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child appear stubborn about rituals and routines?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child have very limited interests in toys or play?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your child receiving any special education services at school?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If you answered yes to any questions, please describe:**

<table>
<thead>
<tr>
<th>Has your child ever been diagnosed by a psychologist, neurologist, or other professional as having autism or autism spectrum disorder?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**If yes, please describe the types of intervention programs or therapies your child has received or is currently receiving:**

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Dates/Ages (from, to)</th>
<th>Location/Provider (home, school, clinic)</th>
<th>Frequency/Duration (minutes per week)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral therapy (e.g., ABA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech/language therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Play therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social skills group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Steps services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Child's History

The following questions are asked so that we can best understand your child. Please fill out this questionnaire before the child is evaluated. Please read the questions carefully and answer them as fully as possible. Use the back of the sheet if necessary. If there are any questions you don't understand, they can be filled out with the examiner's help when he or she reviews the history with you. Please star (*) such questions.

Child's Information

Legal Name: ____________________________ Birth Date: ____________________________ Age: ____________________________

Home Address: ________________________________________________________________

Home Phone: ____________________________

City: ____________________________ State: ____________________________ Zip Code: ____________________________

Child's Doctor: ____________________________ Phone: ____________________________

What are the problems that caused you to seek help for this child?

__________________________________________________________

Family History

Child is living with: ☐ Both parents ☐ Mother ☐ Father ☐ Mother and Stepfather ☐ Father and Stepfather

☐ Legal Guardian ☐ Other (please specify)

Is the child adopted? ☐ Yes ☐ No. If yes, with which parent(s) (if any) does the child live? ☐ natural ☐ adoptive

Child's age at adoption: ____________________________

Status of parents' marriage: ☐ Married How long married? ____________________________

☐ Separated ☐ Divorced How long divorced? ____________________________ Child's age at divorce: ____________________________

☐ Widowed ☐ Single

Birth Mother

Age: ____________________________

Highest grade completed: ____________________________

Diploma/Degree: ____________________________

Occupation: ____________________________

Please describe any special education or tutoring:

__________________________________________________________

____________________________________________________________________

Please describe any grades repeated or subjects failed:

__________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Birth Father

Age: ____________________________

Highest grade completed: ____________________________

Diploma/Degree: ____________________________

Occupation: ____________________________

Please describe any special education or tutoring:

__________________________________________________________

____________________________________________________________________

Please describe any grades repeated or subjects failed:

__________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Birth Mother

Please describe any learning difficulty, and subject and grade level at which it occurred:

__________________________________________________________

Please describe any behavior problems and treatment received:

__________________________________________________________

Please describe any psychological or psychiatric problems for which treatment was received:

__________________________________________________________

Any Attention-Deficit Disorder or hyperactivity? Please describe treatment:

__________________________________________________________

Adoptive Mother/Stepmother/Other
(circle one)

Age: ____________________________

Highest grade completed: __________

Occupation: ______________________

Adoptive Father/Stepfather/Other
(circle one)

__________________________________________________________

Other Children (including step-siblings and half-siblings)

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>In home?</th>
<th>School/behavioral/health problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Biological Extended Family

Do any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) suffer from a problem with inattentiveness or hyperactivity; epilepsy; seizures; migraines; alcoholism or substance abuse; psychological, emotional, or personality difficulty; learning problems or developmental disabilities; and/or a “nervous” or neurological disorder; etc.? □ Yes □ No If yes, please list relationship to child, disorder, and any treatment received:

Maternal (mother’s side)

__________________________________________________________

__________________________________________________________

__________________________________________________________

Paternal (father’s side)

__________________________________________________________

__________________________________________________________

__________________________________________________________

Please provide any other information about the child’s extended family that might help us understand the child’s needs (medical, developmental, behavioral, educational, emotional, or psychological).

__________________________________________________________

__________________________________________________________

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Appendix G: Comprehensive Clinical History Form 275
Infancy And Early Childhood

Please rate the child on the following behaviors: Circle 1 if the behavior on the left was present the majority of the time. Circle 5 if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4. If there are two behaviors listed (e.g., tantrums and head banging), please check the one that was present.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>quiet and content</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>colicky and irritable</td>
</tr>
<tr>
<td>very easy to feed</td>
<td></td>
<td></td>
<td>3</td>
<td>4</td>
<td>5 daily feeding problems</td>
</tr>
<tr>
<td>slept well</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 frequent sleeping problems</td>
</tr>
<tr>
<td>usually relaxed</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 often restless</td>
</tr>
<tr>
<td>underactive</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 overactive</td>
</tr>
<tr>
<td>cuddly, easy to hold</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 did not enjoy cuddling</td>
</tr>
<tr>
<td>easily calmed down</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 □ tantrums □ head banging</td>
</tr>
<tr>
<td>cautious and careful</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 □ accident prone □ daredevil</td>
</tr>
<tr>
<td>coordinated</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 uncoordinated</td>
</tr>
<tr>
<td>enjoyed eye contact</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 avoided eye contact</td>
</tr>
<tr>
<td>liked people</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 disliked contact with people</td>
</tr>
</tbody>
</table>

Other problems or comments regarding infancy or early childhood development: ________________________________________________________________

_______________________________________________________________

Did any event, health condition, separation, etc., disturb early infant/mother bonding or the developing toddler/mother relationship?  □ Yes  □ No  If yes, please explain: ________________________________________________________________

_______________________________________________________________

Please describe the child as an infant (temperament, sleeping, eating patterns, etc.): ________________________________________________________________

_______________________________________________________________

Ages at Milestones

<table>
<thead>
<tr>
<th>Gross Motor Skill</th>
<th>Age</th>
<th>Language Skill</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>crawled</td>
<td></td>
<td>used single words</td>
<td></td>
</tr>
<tr>
<td>walked alone</td>
<td></td>
<td>used sentences (2+ words)</td>
<td></td>
</tr>
<tr>
<td>ran well</td>
<td></td>
<td>described activity</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fine Motor Skill</th>
<th>Age</th>
<th>Social/Adaptive Skill</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>fed self with spoon</td>
<td></td>
<td>potty trained/day</td>
<td></td>
</tr>
<tr>
<td>scribbled</td>
<td></td>
<td>potty trained/night</td>
<td></td>
</tr>
<tr>
<td>tied shoe</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rate of development overall:  □ Slow  □ Normal  □ Fast
Birth and Developmental History

Pregnancy

Length in months: ________

Any illnesses or complications while pregnant? □ Yes □ No If yes, please explain: ____________________________

Medications taken by the mother during pregnancy: ____________________________

Substances used during pregnancy: ____________________________

□ Cigarettes How many? ________ per ( □ day □ week)

□ Alcohol How many drinks? ________ per ( □ day □ week □ month)

□ Drugs Please describe type(s) of drug, frequency of use, and at what month of pregnancy use was stopped (if applicable):

________________________________________

Was the father taking any medications or drugs at time of conception? □ Yes □ No If so, what?

________________________________________

How many pregnancies and/or miscarriages has the mother had? ________

Labor and Delivery

Was the birth of the child “normal”? □ Yes □ No If no, please explain:

________________________________________

Do you think the child’s problems might be related to pregnancy, labor, or delivery? □ Yes □ No If yes, please explain:

________________________________________

Perinatal History

Birth weight ________ Length ________ APGAR scores ________

Did mother or baby stay in Special or Intensive Care? □ Yes □ No

Please describe any problems: ____________________________

________________________________________

Please list any birth defects: ____________________________

________________________________________
Medical History

Has the child been taken to the emergency room with a serious emergency, hospitalized, or had outpatient surgery since birth?  □ Yes  □ No  If yes, please describe condition/injury, treatment, any surgery, when, how long, and where:

________________________________________________________________________

If the child had a head injury: Did he or she lose consciousness?  □ Yes  □ No
If yes, how long?

Was he or she comatose?  □ Yes  □ No  If yes, how long?

Do you see the child as being  □ hyperactive  □ inattentive  □ a behavior problem?

Does the child seem to be able to control his or her behavior and attention?
□ Yes  □ No  If no, please explain: ____________________________________________

Has the child ever been diagnosed by a psychologist, physician, or other professional as having ADHD (Attention-Deficit/ Hyperactivity Disorder)  □ Yes  □ No
If yes, when?

What treatment has the child had for ADHD (other than medications)?  ____________________________________________________________

_______________________________________________________________________

What medication(s) has the child received for ADHD (include dosage and times)?
_______________________________________________________________________

_______________________________________________________________________

Please describe any other handicapping conditions or special health considerations and their treatments: ____________________________________________________________

_______________________________________________________________________

Date of last hearing test: _________  Were the results normal?  □ Yes  □ No
If no, please explain: _____________________________________________________

_______________________________________________________________________

Date of last vision test: _________  Does the child wear  □ Glasses?  □ Contacts?
Why?
_______________________________________________________________________

Please list medications currently being taken by the child, including nonprescription medications (with dosage and times):
_______________________________________________________________________

_______________________________________________________________________

The child's current health is:  □ Poor  □ Fair  □ Good  □ Excellent
Behavioral and Mental Health History
Please describe any behaviors that are particularly concerning to you or others:

________________________________________________________________________

________________________________________________________________________

Please list any unusual, traumatic, or possibly stressful events in the child’s life that you think may have had an impact on his or her development and current functioning. Include incident, child’s age at the time, and comments:

________________________________________________________________________

________________________________________________________________________

Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.?  □ Yes  □ No  If yes, please list any past and current treatments, including type of counseling, person counseled, name of counselor, and length of treatment:
________________________________________________________________________

________________________________________________________________________

Present Personality and Behavior
Please circle all traits that apply to the child now:
sad  happy  leader  follower  moody  friendly  quiet  overactive  independent
dependent  sensitive  affectionate  fearful  cooperative  tantrums  lethargic
too responsible  trouble sleeping  hard to discipline  even-tempered  prefers to be alone

Educational History
Did the child attend preschool or daycare? If so, list location, type of program, number of days per week, age when started, and progress:
________________________________________________________________________

________________________________________________________________________

Current grade and school:
________________________________________________________________________

List previous schools and grades attended at each:
________________________________________________________________________

Briefly describe the child’s performance and any concerns in each grade:
Kindergarten:
________________________________________________________________________
1st grade: __________________________________________________________________
2nd grade: __________________________________________________________________
3rd grade: __________________________________________________________________
4th grade: __________________________________________________________________
5th grade: __________________________________________________________________
Middle School: ____________________________________________________________

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Appendix G: Comprehensive Clinical History Form  279
Has the child been placed in special education programs currently or in the past?
☐ Yes ☐ No  If yes, please describe:

Category: _______________________________________________________

☐ Learning Disability (LD): _______________________________________

(subjects)

☐ Language Disorder: _____________________________________________

(type)

☐ Tutoring: _____________________________________________________

(subjects)

Additional Information

Please attach results of any previous testing.
Please add any additional comments you think might be helpful.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Signature: ____________________________  Date: __________________________

Individual completing form, relationship to child