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CHILD INTAKE FORM

Child's Name: _____ Today's Date:_____

❒ Male ❒ Female Ethnicity:_____ Birthdate:_____ Age:_____

School:_____Phone #:_____

Teacher's Name:_____ Grade:_____

Child's Physician: _____ Phone #: _____

Biological Parent's Marital Status:

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed

Other: _____

Length of marriage/relationship: _____ If divorced, how old was your child? _____

If divorced, How much time does your child spend with each parent? Mother_____%, Father _____%

Current household and family information:

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

Please fill out the sections below for each parent/guardian

Parent/Guardian:_____ Birthdate:_____ Age:_____

❒ Male ❒ Female Ethnicity:_____ Religious Preference:_____

Address: _____

City: _____ Zip Code: _____

Email: _____ May I email you? ❒ Yes ❒ No

Place of Employment: _____ Total years of education:_____

Occupation:_____ Work #: _____

Cell #: _____ Home #: _____

Are there any contact methods through which you DO NOT want me to **call** or **leave a message**? _____

Parent/Guardian:_____ Birthdate:_____ Age:_____

❒ Male ❒ Female Ethnicity:_____ Religious Preference:_____

Address: _____

City: _____ Zip Code: _____

Email: _____ May I email you? ❒ Yes ❒ No

Place of Employment: _____ Total years of education:_____

Occupation:_____ Work #: _____

Cell #: _____ Home #: _____

Are there any contact methods through which you DO NOT want me to **call** or **leave a message**? _____

Person to contact in case of an emergency - Name:_____

Relationship to client: _____Phone #: _____

YOUR FAMILY AND CHILD'S STRENGTHS

At what activities do you feel your son or daughter is successful when he or she tries? _____

_____

What strengths or characteristics stand out in your son or daughter? _____

_____

Who/what are some positive or helpful *people*, *activities* (e.g. walking), or *beliefs* (e.g. religion) in your child's life?

_____

_____

Please share any strengths you have as a family:_____

_____

CURRENT REASON FOR SEEKING COUNSELING

Please briefly describe the problem for which you are seeking counseling:_____

_____

_____

What would you like to see happen as a result of counseling? _____

_____

_____

What is most concerning right now? _____

_____

_____

COUNSELING HISTORY

Has your son or daughter previously seen a counselor? ❒ Yes ❒ No *If yes, where*: _____

Approx. dates and duration of Counseling: _____

For what reason did your son or daughter go to counseling?_____

_____

Please list any previous mental health diagnoses? _____

What did you find **most helpful** about therapy? _____

_____

What did you find **least helpful** about therapy? _____

_____

Has your child used psychiatric services? ❒ Yes ❒ No *If yes, Doctor's Name*? _____

Has your child taken medication for a mental health concern? ❒ Yes ❒ No *If yes, please them below:*

Name of medication	Dates taken	Was it helpful? (Y/N)

Does your son or daughter have other medical concerns or previous hospitalizations? ❒ Yes ❒ No

If yes, please describe: _____

_____

HEALTH AND DEVELOPMENT

This child is number _____ of _____ total children Parent(s) age(s) at child's birth: _____

Was the pregnancy planned? ❒ Yes ❒ No Length of pregnancy: _____

While pregnant, did the mother smoke? ❒ Yes ❒ No *If yes, what amount?*: _____

While pregnant did the mother use drugs/alcohol? ❒ Yes ❒ No *If yes, type/amount?*:_____

While pregnant, did the mother have medical/emotional difficulties? (i.e. surgery, anxiety etc.) ❒ Yes ❒ No

If yes, describe:_____

Were there any complications with the pregnancy or delivery of your child? ❒ Yes ❒ No

If yes, describe: _____

Did your child have health problems at birth? ❒ Yes ❒ No

If yes, describe: _____

Has the mother had any occurrences of miscarriages, stillborn, or loss of a child? ❒ Yes ❒ No

If yes, please describe: _____

Did your child experience any developmental delays (e.g. toilet training, talking)? ❒ Yes ❒ No ❒ Not sure

If yes, describe: _____

Did your child have any unusual behaviors or problems prior to age 3? ❒ Yes ❒ No ❒ Not sure

If yes, describe: _____

Has your child experienced emotional, physical, or sexual abuse? ❒ Yes ❒ No ❒ Not sure

If yes, describe: _____

Date of your child's last physical examination: _____

Please list any chronic health problems or concerns (e.g. asthma, migraines, hyperthyroidism, chronic pain, seizures, etc.): _____

_____

Has your child ever been hospitalized? □ Yes □ No

If yes, when and what happened?_____

Any Allergies? □ Yes □ No *If yes,* please list:_____

Current Medications:_____

Has your child ever had a head injury? □ Yes □ No

If yes, when and what happened?_____

_____

Infant/Toddler: *Check all that apply*:

___ Breast fed	___ Milk allergies	___ Vomiting	___ Diarrhea
___ Bottle fed	___ Rashes	___ Constipation	___ Colic
___ Not cuddly	___ Cried often	___ Rarely cried	___ Overactive
___ Resisted solid food	___ Trouble sleeping	___ Irritable when awakened	___ Lethargic

Developmental History: *Please circle* "E" for early, "A" for average, or "L" for late on the following:

Sat alone:	E	A	L	Dressed self:	E	A	L
Took 1st steps:	E	A	L	Tied shoe laces:	E	A	L
Spoke words:	E	A	L	Rode 2 wheel bike:	E	A	L
Spoke sentences:	E	A	L	Toilet trained:	E	A	L
Weaned:	E	A	L	Dry during day:	E	A	L
Fed self:	E	A	L	Dry during night:	E	A	L

Compared with siblings, child's development was: Slow _____ Average _____ Fast _____N/A_____

EDUCATION

Type of school: _____Public _____Private _____Home Schooled _____Other: _____

School Counselor Name: _____ Phone #: _____

In special education? ❒ Yes ❒ No

If yes, describe: _____

In gifted program? ❒ Yes ❒ No

If yes, describe: _____

Has your child ever been held back in school? ❒ Yes ❒ No *If yes, what grade(s)?* _____

Which subject(s) does your child enjoy in school: _____

Which subject(s) does your child dislike in school: _____

What grades does your child usually receive in school? _____

Any recent changes in grades? ❒ Yes ❒ No

If yes, describe: _____

Any past psychological or academic testing? ❒ Yes ❒ No

If yes, describe: _____

Has your child ever been bullied? ❒ Yes ❒ No ❒ Not sure

If yes, describe: _____

Check the descriptions that specifically relate to your child:

Child's feelings about School Work:

___Anxious	___Passive	___Enthusiastic	___Fearful
___Eager	___No expression	___Bored	___Rebellious

Child's approach to School Work:

___Organized	___Industrious	___Responsible	___Interested
___Self-directed	___Lacks initiative	___Refuses	___Sloppy
___ Does minimum	___Disorganized	___Cooperative	___ Incomplete

___Other (describe): _____

Child's performance in School (Parent's Opinion):

___Satisfactory ___Underachiever ___Overachiever

___Other (describe) _____

PEER RELATIONSHIPS

How would you describe your child in social situations?

___Spontaneous ___Follower ___Leader ___Apathetic about making friends
___Makes friends easily ___Shares easily ___ Long term ___Trouble making friends

___Other (describe):_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Please list any electronic communication (e.g. FaceBook, Twitter, SnapChat, Instagram, etc) that your child uses:

_____

Do you have access to your child's electronic communication? ❒ Yes ❒ No

Do you have any concerns with your son or daughter using the internet or electronic communication such as

Facebook, Snapchat, Twitter, texting etc.? ❒ Yes ❒ No

If yes, please explain your concern: _____

_____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? ❒ Yes ❒ No

If yes, please explain your concern: _____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant impact on you

or your child in the past: _____

_____

FAMILY HISTORY

Did **you/your spouse** experience any abuse as a **child** (physical, verbal, emotional, or sexual)? ❒ Yes ❒ No

If yes, please describe as much as you feel comfortable: _____

_____

_____

Did **you/your spouse** experience any abuse as an **adult** (physical, verbal, emotional, or sexual)? ❒ Yes ❒ No

If yes, please describe as much as you feel comfortable: _____

_____

_____

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Please circle any that apply and list the family member, e.g., sibling, parent, uncle, etc.):

Difficulty		**Family Member(s)**
Depression	yes/no	_____
Bipolar Disorder	yes/no	_____
Anxiety Disorders	yes/no	_____
Panic Attacks	yes/no	_____
Schizophrenia	yes/no	_____
Alcohol/Substance Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Learning Disabilities	yes/no	_____
Trauma History	yes/no	_____
Suicide Attempts	yes/no	_____
Psychiatric Hospitalizations	yes/no	_____

CURRENT FAMILY CONCERNS (*Please check all that apply*)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

As the father, how would you characterize your relationship with your child? Poor ❒ Fair ❒ Good ❒

As the mother, how would you characterize your relationship with your child? Poor ❒ Fair ❒ Good ❒

Who handles responsibility for your child in the following areas?

School: ___ Mother ___Father ___Shared ___Other _____
Health: ___ Mother ___Father ___Shared ___Other _____
Problem Behavior: ___ Mother ___Father ___Shared ___Other _____

Is there anything significant about the parents' relationship that might be affecting the child's behavior? ❒ Yes ❒ No

*If yes, please describe:*_____

_____

Have there been stressful events in the child's life in the last 18 months (i.e. moves, deaths, injuries, etc.)? ❒ Yes ❒ No

*If yes, please describe:*_____

_____

Please use the space below, or the back, if there is anything else you would like to share: *(Then, proceed to the next page)*

CONCERNS REGARDING YOUR CHILD (*Please check one box for each symptom*)

SYMPTOM	*NONE*	*MILD*	*MOD*	*SEVERE*	SYMPTOM	*NONE*	*MILD*	*MOD*	*SEVERE*
Sadness					**Appetite changes**				
Crying					**Social isolation**				
Sleep disturbances					**Paranoid Thoughts**				
Problems at home					**Poor Concentration**				
Hyperactivity					**Indecisiveness**				
Binging/purging					**Low energy**				
Loneliness					**Excessive worry**				
Unresolved guilt					**Low self worth**				
Irritability					**Anger issues**				
Nausea/indigestion					**Spiritual Concerns**				
Social anxiety					**Hallucinations**				
Self mutilation					**Racing thoughts**				
Cutting					**Restlessness**				
Impulsivity					**Drug use**				
Nightmares					**Alcohol use**				
Hopelessness					**Easily distracted**				
Elevated mood					**Trauma flashbacks**				
Mood swings					**Obsessive Thoughts**				
Disorganized					**Panic attacks**				
Anorexia					**Feeling anxious**				
Grief					**Feeling panicky**				
Phobias					**Suicidal thoughts**				
Headaches					**Past suicide Attempts**				
Weight changes (unplanned)					**Other:**				