

**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  Cohabiting  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**? \_\_\_\_\_

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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:

- |  |   |  |                                     |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Breast fed          | <input type="checkbox"/> Milk allergies   | <input type="checkbox"/> Vomiting                | <input type="checkbox"/> Diarrhea   |
| <input type="checkbox"/> Bottle fed          | <input type="checkbox"/> Rashes           | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Colic      |
| <input type="checkbox"/> Not cuddly          | <input type="checkbox"/> Cried often      | <input type="checkbox"/> Rarely cried            | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Resisted solid food | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Irritable when awakened | <input type="checkbox"/> 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 1 <sup>st</sup> 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:* \_\_\_\_\_

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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:* \_\_\_\_\_

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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.):

<b>Difficulty</b>		<b>Family Member(s)</b>
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)*

<u>SYMPTOM</u>	<i>NONE</i>	<i>MILD</i>	<i>MOD</i>	<i>SEVERE</i>	<u>SYMPTOM</u>	<i>NONE</i>	<i>MILD</i>	<i>MOD</i>	<i>SEVERE</i>
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:				