CHILD INTAKE FORM (TO AGE 12)

For Parent/Guardian to Complete

Child's Name:_____ DOB:_____ Age: _____

Home address:

_____

School: _____Grade: _____

Race/Ethnic Origin: _____

Religious Affiliation: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

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

Reason for seeking counseling:

_____

_____

CHILD'S DEVELOPMENT:

1. Were there any complications with the pregnancy or delivery of your child? Y/N
   If yes, describe: _____
2. Did your child have health problems at birth? Y/N
   If yes, describe: _____
3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)? Y/N
   If yes, describe: _____
4. Did your child have any unusual behaviors or problems prior to age 3? Y/N
   If yes, describe: _____
5. Has your child experienced emotional, physical, or sexual abuse? Y/N/Unsure
   If yes, describe: _____

Emotional/Behavioral/Chemical Issues:

(Has your child recently experienced or are they currently experiencing any of the following?)

CONCERN	YES	NO	CONCERN	YES	NO
Suicidal thoughts			Difficulty sleeping		
Suicide plans			Depression,		
Suicide attempts			loneliness, or hopelessness		
Self-inflicted injury behaviors			Crying often		
A tendency to be shy or sensitive			Frightening dreams or thoughts		
A strong dislike of criticism			Often annoyed by little things		
A frequent loss of temper			Difficulty completing tasks		
Difficulty expressing feelings			Violent or destructive behavior		
Nervousness, anxiety, or worry			Difficulty remembering		
Difficulty relaxing			Difficulty concentrating		
Difficulty making decisions			Mental Confusion		
Difficulty making friends			Difficulty with eating		

1. Has your child ever been in court or picked up by the police? Y/N
   If yes, describe: _____
2. Do you think your child has tried or is using cigarettes, sniffing, alcohol or drugs? Y?N
   If yes, describe: _____

PEER RELATIONS

1. Is your child socially: ___outgoing ____shy ____depends on the situation.
2. Has your child experienced any bullying? Y/N
3. Is your child involved in any organized social activities (e.g. sports, scouts, music)? Y/N

List activities_____

SCHOOL HISTORY:

1. Has your child ever been held back a grade? Y/N

   If yes, what grade and what was the reason you choose to hold your child back:_____
2. What are the grades your child receives at school? _____
3. Do you feel your child is doing the best he/she can at school? Y/N
4. Are there any behavior problems at school? Y/N
   If yes, please explain: _____
5. How many schools has your child attended? _____

DISCIPLINE:

1. Are there any concerns in regards to discipline? Y/N
   If yes, please explain: _____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE:

1. Does your child have a cell phone Y/N

2. How many hours of screen time *(computer, video games, TV)* does your child engage in daily? _____
3. Do you have concerns related to internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? Y/N

If yes, please explain your concern: _____

MEDICAL HISTORY:

More than one category may be checked.

CONCERN	NEVER	0-6 MONTHS	7-12 MONTHS	1-2 YEARS	2-4 YEARS	4-6 YEARS	SINCE 6 YEARS	CURRENT CONCERN
High fever (over 103°)								
Seizures (convulsions)								
Rashes or skin problems								
Meningitis								
Asthma								
Food allergies								
Other allergies								
Pneumonia								
Meningitis								
Anemia (low blood count)								
Heart problems								
Kidney or urinary problems								
Bowel problems								
Trouble with vision								
Trouble with hearing								
Lack of weight gain								
Poisoning or medication overdose								
Serious injury								
Hospitalization								
Surgery								

1. Other important illnesses not listed: _____
2. Does your son or daughter have other medical concerns or previous hospitalizations? Y/N

   If so, please describe. _____
3. Inherited conditions (e.g. Huntington's Chorea, Sickle Cell Anemia): _____

COUNSELING HISTORY:

1. Have your son or daughter previously seen a counselor? Y/N
2. Approximate Dates of Counseling:_____
3. For what reason did your son or daughter go to counseling?
   _____
4. Does your son or daughter have a previous mental health diagnosis? Y/N
   If yes, what is it? _____
5. What did you find helpful in therapy?
   _____
6. Has your son or daughter used psychiatric services? Y/N
7. Has your son or daughter taken medication for a mental health concern? Y/N
   If yes, please list here: _____
   _____

CHILD'S STRENGTHS ***(Please mark those strengths that you have observed in your child):***

	Often True	**Sometimes True**	**Seldom True**	**Cannot Say**
Outgoing				
Self-confident				
Seems happy				
Friendly				
Enjoys new experiences or activities				
Even disposition or steady moods				
Expresses feelings				
Affectionate				
Kind or sympathetic to others				
Shares				
Can compromise				
Follows rules easily				
Is forgiving				
Stands up for self when appropriate				
Tolerates criticism				
Recovers easily after disappointment				
Is appropriately cautious				
Creative				
Plays gently with smaller children or animals				
Good sense of humor				
Other				

PARENTAL HISTORY

Current Marital Status of Biological/Adoptive Parents:

❒Single ❒Married ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed

1. Length of marriage/relationship:_____
2. If divorced, how old was your child at time of divorce? _____
3. If divorced, How much time does your child spend with each parent? Mother___%, Father___%

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Biological Father's Name: _____Birth Date:_____ Age: _____

Address: _____

Phone: _____ Email: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Biological Mother's Name: _____Birth Date:_____ Age: _____

Address: _____

Phone: _____ Email: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N Combat experience? Y/N

Assessment of current relationship if applicable: Good _____Poor_____ Fair_____

1. Does any parent/caregiver have difficulties with nervousness, anxiety, or depression? Y/N
2. If yes, please explain: _____
3. Does any parent/caregiver have difficulties with anger, e.g. losing temper easily, verbally abusive, being violent when angry? Y/N
4. If yes, please explain: _____

5. **FAMILY ILLNESSES/DISORDERS**

	Mother's Family	Biological Mother	Biological Father	Father's Family
Anxiety disorders				
ADHD or ADD				
Seizure disorder				
Depression				
Schizophrenia				
Other psychiatric disorder				
Learning difficulties				
Behavioral problems				
Alcoholism or drug dependence				

Any additional information you feel is important: _____

_____

_____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

CANCELLATIONS: If you find it necessary to cancel a scheduled appointment, 24 hours' notice is required. With less than 24 hours advance notice, you will be responsible for the full fee before another session can be scheduled. Exceptions made for serious illness or an emergency.

Counseling Agreement: ***My signature affirms that I understand and agree to the contents of this statement, have read and understand the following documents, and consent to counseling as described above:***

____I have received a copy of the Client Information & Policy Statement.

____I have read and agreed to the payment/cancellation policy.

Client Name _____

Parent Name _____

Parent Signature_____Date_____

Counselor Name _____

Counselor Signature _____Date _____