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CHILD INTAKE FORM

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Child's Name:

Today's Date:

Child's age:

Date of Birth (DOB):

Address:

Parent's Name:

Parent's Name:

Home phone:

May I leave a message? Yes No

Cell phone:

May I leave a message? Yes No

Work phone:

May I leave a message? Yes No

Email:

May I email you? Yes No

(For appointment scheduling purposes only, as email is not considered a confidential medium of communication).

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems):

What are your hopes regarding your child's therapy?

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems?

Has your child ever been treated for any of the following? If so please circle and describe:
Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions:

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

Please list your child's current prescription medications with dosage (psychiatric and general health):

Please list any previous psychiatric medications (with dosage and dates):

Do you suspect or know your child drinks alcohol or uses recreational drugs? If so, what kind & how often?

Do you or anyone close to your child consider his/her use to be a problem? Yes No

Who is your child's primary care physician?

Who is your child's psychiatrist (if applicable)?

When was your child's last complete physical exam (mo/year)?

How many times a week does your child exercise?

What type & how many minutes?

What types of food does he/she often eat?

YOUR CHILD'S FAMILY

	BIOLOGICAL MOTHER	BIOLOGICAL FATHER
Current age, or if deceased, date, age, & cause of death		
Country of Origin		
Occupation		
Religious/Spiritual Affiliation (if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred?

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody?

Please describe the current visitation schedule (if any) and type of communication with child's other parent:

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	<u>Please circle</u>	<u>List Family Member(s)</u>
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

Were any problems detected in your child's kindergarten screening? Yes No If so, please explain:

Is your child in a regular classroom? Yes No Does your child have an IEP ? Yes No
Has your child ever received tutoring? Yes No If so, please explain:

What are your child's typical grades?

What are your child's strongest and weakest points academically?

Are you satisfied with your child's educational program? Yes No Please explain:

Home/Family Life

What are 5 things that you enjoy most about your child?

What are some activities you engage in as a family?

Does your child participate in any religious or faith based group?

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques?

What are your strengths personally and as a parent?

What are some of your areas of needed growth?

What are your child's strengths (things he/she is good at)?

What are your child's areas of needed growth?

Social and Community Engagement

What are your child's favorite activities or hobbies?

In what extracurricular/community activities is he/she involved?

How does your child get along with other children?

Who are some of your child's closest friends (first name)

Your Child's Symptoms or Problems

How much are each of the following areas currently a problem for your child?

	Not at all	A little	Somewhat	Often	Always
	1	2	3	4	5
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? Yes No

(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No

If yes, please describe:

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: