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Child Intake Form

Today's Date:

Please provide the following information about your child:

Child's Full Legal Name:		Nick Name:	
Home Address:		City, State, Zip:	
Age:		DOB:	

Mother			
Mother's Name:		Mother's DOB:	
Home Address:		City, State, Zip:	
Email Address:		Contact Method	☐ Email ☐ Phone
Employer:		Position:	
Highest Level of Education			

Father			
Father's Name:		Father's DOB:	
Home Address:		City, State, Zip:	
Email Address:		Contact Method	☐ Email ☐ Phone
Employer:		Position:	
Highest Level of Education			

May I leave messages at these numbers? Please circle yes or no for each.

Mother			Father		
Cell Phone:		Yes No	Cell Phone:		Yes No
Work Phone:		Yes No	Work Phone:		Yes No
Home Phone		Yes No	Home Phone		Yes No

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Family Histroy

In the case of divorce of the parents for this child: The most recent court documents regarding custody and which parent has the right to seek mental health treatment must be brought to the first appointment so that I can legally discuss your child with you.

Who has legal guardianship of your child?

With whom does your child currently live?

Name:	Age:	Relationship to Child

Is there anyone else significant in the child's life who does not live with the child?
(this can be step parents, grandparents, etc)

Name:	Age:	Relationship to Child

Education History

What school does your child attend? _____
School Address: _____ City, State, Zip: _____
Phone: _____ Teacher: _____
Current Grade:

What does your child's teacher say about him/her? _____

Other schools attended *(including Pre-school)* _____

Has your child ever repeated a grade? If so which one(s)? _____

Does your child received Special Education services, GT, Speech Therapy or Occupational Therapy?

◯ Yes ◯ No

Has your child experienced any of the following problems at School? *check all that apply*

☐	Fighting	☐	Lack of friends
☐	Suspension	☐	Learning disabilities
☐	Incomplete homework	☐	Behavior Problems
☐	Drugs or Alcohol	☐	Poor Attendance
☐	School Refusal	☐	Grade Changes
☐	Bullying/Teasing	☐	Other (please explain)

Medical History

What is the name of your child's medical doctor? _____
Doctor's Address: _____ City, State, Zip: _____
Phone: _____ Date of Last Exam: _____

Please list any medications your child takes on a regular basis: _____

Who prescribed this medication:

Would you like to sign a release of information form so that I can discuss your child's care with their doctor?

◯ Yes No ◯

Please describe any past counseling that your child or any family member has had.

Do you believe it was helpful? Why or Why not?

Name of Counselor: Phone:

Has your child experienced any of the following medical problems? *check all that apply*

☐	A serious accident	☐	A head injury
☐	Eye/ear problems	☐	Allergies
☐	Tics	☐	Hospitalization
☐	High fever	☐	Surgery
☐	Asthma	☐	Convulsions/seizures
☐	Meningitis	☐	Hearing problems
☐	Loss of consciousness	☐	Weight change
☐	Digestive Problems	☐	Appetite Change

Please list any current medical problems or physical handicaps:

Other History

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so please describe:

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

sdaf
asdf
asdf
asdf
sadf

Has he/she ever purposely hurt himself or another? If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain.

Finally, what are some of the things that are currently stressful to your child and his/her family?

These stresses can include any of the following:

- ☐ Change in Schools
- ☐ Family Fighting
- ☐ Divorce/Separation
- ☐ Change in Financial Status
- ☐ Death of a pet
- ☐ Death in the family
- ☐ Other, please explain:
- ☑ Family Move
- ☑ Marital Problems
- ☑ Marital Reconciliation
- ☐ Serious Illness of a Family Member
- ☐ Sibling Issues
- ☐ Death of a close friend

Behavioral Excesses:

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:

What does your child do that you like? What does he/she do that other people like?

Strengths/Limitations:

What are your child's greatest strengths?

What are your child's most difficult limitations?

Others Concerns:

Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Recreation

If your child participates in any of the following activities please indicate their level of participation.

Please check all that apply

	Activity	Which Type(s)?	How often?
☐	Sports		
☐	Fine Arts		
☐	Outside Play with others		
☐	Social Activities		
☐	Religious Activities		

		Hours Per Day?	Hours Per Week?	As A family?
☐	Video Games			
☐	Computer/iPad			
☐	TV			

Additional Concerns

Are there any other issues that you believe I should be aware of?

Signature

Printed Name of Parent/Guardian

Child's Name

Signature of Parent/Guardian

Date