CHILD INTAKE

(To be completed by parent or legal guardian)

Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_Gender: M\_\_\_ F\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Legal Guardian (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child currently lives with: [ ] biological family [ ] relatives [ ] foster care [ ] other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Name (Living with) | Age | Relationship to Child |
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List significant others **NOT** living with your child

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| Name | Age | Relationship to Child |
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Past counseling your child has received:

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| When | Where | Purpose | Outcome |
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Has your child received a previous psychological diagnosis? No\_\_\_ If Yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Medical History:

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any health concerns?

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Has your child experienced any of the following medical problems? (Please check any that apply)

\_\_\_ a serious accident \_\_\_ convulsions/seizures \_\_\_ meningitis \_\_\_asthma

\_\_\_ a head injury \_\_\_ hospitalization \_\_\_ loss of consciousness \_\_\_allergies

\_\_\_ eye/ear problems \_\_\_ high fever \_\_\_ surgery \_\_\_ hearing problems

Please list any regular medications the child takes (including quantity and frequency of dosage)

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Educational History: Child’s School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_

Teacher’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher’s current evaluation of child:

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List special educational services (if applicable):

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Has the child ever repeated a grade? No \_\_\_\_ Yes\_\_\_\_ If Yes, which grade? \_\_\_\_\_

List child’s problems at school (place check all that apply):

\_\_\_ fighting \_\_\_ detention \_\_\_ incomplete homework \_\_\_ bullied

\_\_\_ lack of friends \_\_\_ suspension \_\_\_ disruptive behavior \_\_\_ poor attendance

\_\_\_ poor grades \_\_\_ learning disabilities \_\_\_ drug/alcohol use \_\_\_ other

Behavior Factors:

Excess: What misbehaviors does your child currently display too often or at inappropriate times?

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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?

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Assets: What does your child the child do that you or others like?

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List any other concerns within your family that may affect your child

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Other Significant Factors:

Family use (current and/or past) of any drugs, tobacco or alcohol (please describe including quantity and frequency of substance):

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Has your child ever experienced abuse? (physical emotional, sexual or verbal) No \_\_\_\_ Yes \_\_\_\_\_ If yes, please explain:

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Has your child ever made statements of wanting to seriously hurt him/herself or another OR has your child ever purposely hurt him/herself or another? No \_\_\_ Yes \_\_\_ If yes, please explain fully:

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Has your child ever experienced serious emotional loss? (deaths, separations, etc.) No\_\_\_ Yes \_\_\_If yes, please explain:

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What things currently stress your child and/or child’s family?

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Treatment Goals: What concerns with your child do you want addressed first in therapy?

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Signature of Parent of Legal Guardian Date