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CHILD AND FAMILY INTAKE FORM

Please fill out the entire form, answering the questions as they pertain to your child or teen. Leave blank any that are unclear or that you want additional clarification on. Thank you.

General Information

Child's name: _____Nickname: _____Date of Birth: _____/_____/_____

Sex: Male _____ Female _____ SSN: _____ Today's date: _____/_____/_____

Parent's Name: _____Home phone: (____) _____ Cell: (____) _____

Address:_____ City: _____ State: _____ Zip: _____

Employer: _____Work phone: (_____) _____ Email: _____

Parent's Name: _____ Home home: (____) _____ Cell: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work phone: (____) _____ Email: _____

Who will be responsible for making/keeping appointments? _____

Ok to leave phone message? Yes No Which number? _____ Ok to send mail? Yes No

Emergency contact/Relation: _____ Phone: (____) _____ Alt phone:(____)_____

Child's primary care provider: _____Clinic name/phone:_____

Allergies: _____ Medical conditions: _____

Grade level and school: _____Interests/hobbies: _____

I was referred by: _____

Insurance Information

Insurance Provider: _____Subscriber's name: _____Subscriber's birthdate: _____/_____/_____

Name of employer: _____ Subscriber's address (if different than above): _____

Insurance phone: _____ Address: _____

ID#: _____ Group #: _____

**A copy of your card will be made if you would like your insurance to be billed for reimbursement.

Therapy Goals and History

What brings you and your child in? When did these concerns arise?

_____

_____

_____

What has already been tried to help your child? _____

_____

What would you like to be different?

_____

Who supports you and your family in your decision to begin counseling? _____

Has your child seen a therapist before? Yes ____ No ____ When? _____From 1-10, rate previous experiences: _____

Name(s) of previous therapist(s): _____ Phone: (____) _____

_____

What helped? _____ What didn't? _____

Has any family member had counseling in the past? Please describe: _____

_____

Is any family member currently in treatment with another mental health provider? Please describe: _____

_____

Family History

Who lives in the home? Names, ages, relationship, any problems:

_____

_____

_____

Any brothers or sisters NOT living the in the same home as the child? Please specify name, age, job/school, any problems:

_____

_____

Who are the significant adult figures in your child's life? _____

_____

Describe significant changes/transitions in your child's life and the age that they occurred. For example, divorce (please describe the events surrounding the divorce, reason for divorce, age of child), moves, change in schools, death/loss, removal

from parents' care.

If parents are divorced or separated, what are the current custody and visitation arrangements? _____

Are you the primary custodian of this child? If not, is it share, joint, guardianship, etc? _____

Educational History

Has the child ever been held back? Y N

Does the child receive special education services (e.g., IEP or 504 plan)?_____

What kinds of grades does the child receive?

Math?_____Reading?_____Writing?_____

Has a psychoeducational evaluation ever been done by the school?_____

If yes, when?_____Can the results be obtained? Y N

Does your child's teachers have any concerns regarding your child's behavior? Have they in the past?_____

Has your child ever been suspended or expelled for behaviors? Y N When?_____

List all schools your child has attended:

Name of school Years attended

Is this child involved in extracurricular activities, private lessons, church groups, teams, etc?_____

Any problems in participation in group activities? Y N _____

_____

Who are your child's closest friends? What do you think of them?_____

_____

_____

_____

Social-Emotional Issues

Does your child:

_____Do any rocking behaviors
_____Withdraw from others
_____Wet self during the day
_____Talk in sleep
_____Set fires
_____Steal
_____Bite others
_____Play alone
_____Enjoy school
_____Have difficulty going to sleep
_____Suck thumb
_____Wet at night
_____Soil self
_____Have nightmares
_____Go to bed alone
_____Hurt animals
_____Break things
_____Hit others
_____Self-injure
_____Engage in high-risk play
_____Seem to be accident prone
_____Sleep walk
_____Run away
_____Cry easily
_____Play well with others
_____Have temper tantrums

Does your child:

_____Demonstrate poor eye-to-eye gaze when conversing
_____Have increased sensitivity to loud/sudden noises
_____Have repetitive or odd body postures
_____Fail to make and maintain friendships with peers
_____Spontaneously seek to share his enjoyment, interests, or achievements with others
_____Have an impairment in his/her ability to initiate or sustain a conversation
_____Engage in make believe play or social imitative play
_____Engage in ritualistic or compulsive behaviors

What forms of discipline have you used for your child?_____

_____

What works? What doesn't?_____

Do both parents agree on kind and amount of discipline? Y N

Does this child have any unusual or intense fears? Please circle:

Dark
Heights
Crowds
Fire
School
Being away from parents
Exaggerated concerns about his/her health
Being away from home
Animals
Others?_____

Have you ever seen your child have a severe anxiety or panic reaction? Describe:_____

_____

Has this child ever been separated from you? (When, why, and who cared for the child?)_____

Has this child witnessed angry verbal or physical verbal arguments between adults?_____

Has this child ever had reason to fear the loss of a parent?_____

Has this child ever had reason to fear the loss of another close family member?_____

Does this child have any involvement or previous record with juvenile authorities?_____

Symptom Checklist

Check 0, if you are not currently concerned about the symptom; 1, if it is a mild concern; 2, if it is a moderate concern and 3, if it is a serious concern.

Symptom	0	1	2	3	**Symptom**	0	1	2	3
Depression mood/sadness					Sleep trouble				
Grief and Loss					Fatigue/low energy				
Loss of appetite					Weight gain or loss				
Apathy or lack of motivation					Suicidal thoughts or attempts				
Substance Abuse					Feelings of worthlessness				
Headaches/Stomach pain					Social isolation				
Guilt/Shame					Poor attention or focus				
Hyperactivity					Self-esteem issues				
Mood swings					Unusual or racing thoughts				
Anger					Aggression/violence				
Anxiety or worry					Panic attacks				
Phobias					Obsessions				
Compulsive behavior					Victim of abuse or trauma				
Feeling detached or distant					Hearing or seeing things				
Self-harming or cutting					Difficulties keeping/making friends				
Exposure to domestic violence					Legal trouble				
Learning difficulties					Toileting issues				
Behavior concerns at school					Tantrums/fits				
Poor grooming/hygiene					Irritability				

Bingeing/purging					Anorexia				
Tearfulness					Victim of a crime				
Defiance/oppositional behavior					Other:_____				
Nightmares					Other:_____				
Other:_____					Other:_____				

Psychiatric Treatment History

Does anyone is the child's family or household have any of the following (include parents, brothers, sisters, grandparents, aunts, uncles, and cousins). Please note who the person is in relation to the child:

_____Depression
_____Bi-polar
_____Nervous breakdowns
_____Psychiatric hospitalizations
_____Alcoholism or heavy drinking
_____Suicide
_____Special education services
_____Victim of sexual child abuse
_____Autism or Aspergers
_____School problems
_____Stealing
_____Seizures
_____Mental retardation
_____Neurological conditions
_____Eating disorder
_____Police record
_____School failure

Has your child seen a psychiatrist in the past? Yes ____ No ____ Name/phone: _____

Is he or she currently seeing a psychiatrist? Yes ____ No ____ Name/phone: _____

Current medications and supplements, along with dosage: _____

_____

_____

Has your child been hospitalized for emotional, psychological or substance use issues? Yes ___ No ___

If yes, when and for how long: _____

Location/Facility name: _____

Child's Developmental History

How old was the mother when this child was born? _____ Father? _____

How many pregnancies had mother had before this child? _____

Were there any complications with the pregnancy and delivery of your child? _____ If yes, explain. _____

_____

_____

During your pregnancy with this child, did mother have: _____x-rays, _____illness, _____smoking, _____medication(s), _____alcohol use, _____high blood pressure, _____illicit drug use, _____prenatal care

Child's birth:
Was baby full term? Y N Length of labor _____, Incubator required? Y N

APGAR Score _____; Birthweight _____, Resuscitation required? Y N

Did baby go home with mother? Y N If not, when?_____

As a baby, did this child have any feeding problems? Please describe:_____

_____

Bottle or breast fed? _____

Did you have to wake the baby for feedings?_____

Was it hard to start solids?_____

At what age was s/he weaned from breast or bottle?_____

At what age did this child (if you can't remember exact age in months, please indicate if development seemed within normal limits in this area)

Sit_____ Say first words_____

Stand_____ Use sentences_____

Crawl_____ Walk_____

Become potty-trained_____ Was potty training_____easy_____hard

Did your child ever do something s/he cannot do anymore?_____

_____

Was your child: (please circle)

Cuddly	Sickly	Hard to schedule
Afraid of strangers	Healthy	Fearful
Good	Smiley	Active
Irritable	Difficult	
Shy	Want to be held	

Do you remember any remarkable or unusual/concerning behaviors from this child from birth to 3 years old? Please describe:_____

_____

How old was this child when mother and/or father returned to work?_____

Who has done or currently provides child care?_____

Have you or anyone else had concerns about your child's development? _____ If yes, explain. _____

_____

_____

Have you or anyone else had concerns about your child's social development? _____ If yes, explain. _____

_____

_____

Have you or anyone else had concerns about the intellectual or academic functioning of your child? _____ If yes, explain.

_____

_____

Medical History

Has your child had:

Allergies	Y N	Hydrocephalus	Y N
Hearing problems	Y N	Encephalitis	Y N
Speech problems	Y N	Seizure/convulsions	Y N
Vision problems	Y N	First menstrual cycle	Y N N/A
Asthma	Y N		
Meningitis	Y N		

Describe any current health problems:_____

_____

Has this child every been hospitalized? Y N Please describe when, where, what for, and for how long:_____

_____

_____

Has this child had any significant injuries? Y N Describe:_____

_____

Has this child had any history of physical, sexual, and/or emotional abuse? Y N _____

_____

_____

Any operations? Y N _____

Does any other family member have a serious or chronic medical condition? Y N _____

_____

Has this child ever had any suicidal ideation or attempted any suicidal gesture?_____

_____

Is this child sexually active to your knowledge?_____

Substance Use Inventory

Does this child have any known or suspect use of drugs/alcohol?_____

Please indicate if your child has used or is currently using the following substances. Please list other family members who have used or are currently using.

	Age of child's first use	When last used	Current frequency and amount	Previous treatment	Family members with past or current use issues
Alcohol				Yes No	
Marijuana/ Hashish				Yes No	
Meth/"Speed"				Yes No	
Cocaine/Crack				Yes No	
Heroin				Yes No	
Prescription drugs				Yes No	
Inhalants				Yes No	
Ecstasy/Molly				Yes No	
Mushrooms				Yes No	
Caffeine				Yes No	
Nicotine				Yes No	
Other:				Yes No	
Other:				Yes No	

Parental Childhood History:

MOM:
Primary Daily Caretaker_____
Number of siblings_____Were your parents divorced during your childhood? Y N
Any history of emotional illness or chemical dependency?_____
Any family member chronically ill?_____
Parents' education?_____
Style of discipline and parenting?_____
Were you adopted? Y N
Other information?_____

DAD:
Primary Daily Caretaker_____
Number of siblings_____Were your parents divorced during your childhood? Y N
Any history of emotional illness or chemical dependency?_____
Any family member chronically ill?_____
Parents' education?_____
Style of discipline and parenting?_____
Were you adopted? Y N
Other information?_____

Socioeconomic History:

Living Situation

Housing Adequate ❒
Homeless ❒
Housing overcrowded ❒
Housing dangerous/deteriorating ❒
Living companions unstable ❒

Family Financial Situation

No current financial stress ❒
Large debt ❒
Low income ❒
Impulse spending ❒
Relationship conflict over money ❒

Parental Legal History

No legal problems ❒
Parole/probation ❒
Arrest(s) not substance related ❒
Arrest(s) substance related ❒
Jail/Prison time ❒

Employment

Employed and satisfied ❒
Employed but dissatisfied ❒
Unemployed ❒
Conflicts at work ❒
Unstable work history ❒
Disabled ❒
Student/underage ❒

Family's Social Support System

Supportive network of friends and family ❒
Few friends ❒
New to the area ❒
No friends ❒
Geographically or emotionally distant from family ❒

Cultural and Spiritual History

Cultural identity: _____Spiritual identity: _____

Importance of spirituality/religion: Low Med High

Is your child or family currently active in your community? _____If so, describe: _____

Does your child or family currently engage in spiritual activities? _____If so, describe:_____

Thank you for filling out this form! I know it is time consuming, but it is greatly appreciated and quite helpful. I look forward to meeting you at our first appointment.