CHILD INTAKE FORM

For children under the age of 13

Child's Name ______________________________ Sex ______ Age _____ DOB ________________

Address ____

Natural Child: Yes / No If adopted, at what age______ Foster since _____________

Custodial Parents:

Parent/Guardian #1 Name ______________________________________ Birth or Step? ________

Cell # ____________________ Occupation ______________________ Employer __________________

Parent/Guardian #2 Name ______________________________________ Birth or Step? ________

Cell # ____________________ Occupation ______________________ Employer __________________

Non-Custodial Parents (if applicable):

Parent/Guardian #1 Name ______________________________________ Birth or Step? ________

Cell # ____________________ Occupation ______________________ Employer __________________

Parent/Guardian #2 Name ______________________________________ Birth or Step? ________

Cell # ____________________ Occupation ______________________ Employer __________________

If divorced/separated, when did this occur? (if applicable) ______________________________________

Comments about custody and visitation (if applicable) ______________________________________

____

____

Primary reason(s) you are concerned about your child?

____

____

SYMPTOM/PROBLEM CHECKLIST

Circle any symptom that is a concern. How long has it been a problem?

1

Sleep problems
Lack of interest in activities
Unassertive
Fatigue/low energy
Concentration problems
Appetite/weight changes
Withdrawal
Forgetful/memory problems
Short attention span
Aggressive behavior
Can't sit still
Not interested in peers
Picked on / bullied by peers

Morbid thoughts
Suicidal thoughts or threats
Suicidal plans / attempts
Mood swings
Depression
Changed level of activity
Cries easily

Excessive worry / fearfulness
Anxiety or panic attacks
Social fears, shyness
Separation problems
Bedwetting / soiling
Headaches, stomachaches
Odd beliefs / fantasizing

Talks excessively / interrupts

Easily distracted
Irritable
Impulsive
Difficulty following rules
Problem completing schoolwork

Lying
Trouble with the law
Running away
Truancy, skipping school
Hurting others sexually
Alcohol / drug use
Argumentative / defiant
Swears
Blames others for mistakes

Nightmares
Frequent tantrums
Resistive to change
School refusal
Perfectionism
Odd hand / motor movements
Hallucinations

Stealing
Being destructive
Fire setting
Hurting others / fighting
Acts as if has no fear
Short tempered
Easily annoyed / annoys others
Discipline problem
Angry and resentful

SIBLINGS

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)

SCHOOL HISTORY

Present School: ______________________________Grade: ____ Teacher: ____________________

Has child ever repeated any grade? ____

Is child in special education services? No___ Yes___ IEP? ____ Type of service________________

Please describe academic or other problems your child has had in school: ____________________

____

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

Pregnancy

Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____

Delivery: Normal _____ Breech _____ Cesarean _____ Transectional _____ Full-term _____

Premature _____ if premature, number of weeks ______ Birth Weight: __________

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc.)

____

Developmental History

State approximate age when child did the following:

Crawled____ Walked alone_____ Said first word _____ Used 2-word phrases _____

Understood and followed simple directions _____ When toilet trained _____

Did child cry excessively? _____ Rarely cried _____

Health History of Child

In the first two years, did your child experience (circle any that apply):

Separation from mother / Out of home care / Disruption in bonding / Parental Stress

Depression of mother / Abuse / Neglect / Chronic pain / Chronic Illness

Child's Doctor/Clinic: ____________________

Date of last physical exam: ____________

Vision problems? No _____ Yes_____ Hearing problems? No _____ Yes _____

Dental problems? No ____ Yes ____

Any head injuries or loss of consciousness? No _____ Yes _____

Child's history of serious illness, injury, handicaps, or hospitalization?

Describe and give dates ____________________

____

Is your child currently taking any medications? No ____ Yes ____

Current medications: ____________________

List any medicines previously used for emotional problems: Were they helpful?

____

Drug/medicine allergies: ____________________

Food allergies: ____________________

Foods that you limit or do not give this child: ____________________

Environmental allergies: conditions? ____________________

Does anyone in the household smoke? No ____ Yes ____

About how many hours does this child watch TV, videos, etc. per day _______

Are you afraid someone you know may injure/harm this child? No ____ Yes ____

(National Domestic Violence Hotline 1-800-799-7233)

Does this child have a Health Care Directive? No ____ Yes ____

If yes, please list where (clinic) it is on file ____

Any previous psychological or psychiatric treatment? No _____ Yes _____

Whom/where ______________________________when______________

Any previous testing (school/psychological)? No _____ Yes _____

Whom/where _______________________________when______________

Do you think your child's use of chemicals is a problem? No _____ Yes _____

Type: Alcohol _____ Marijuana _____ Other drugs ____________________

Comments: ____

Family History:

Parental Chemical use (now & past): No _____ Yes _____ Which parent ______________________

Type: Alcohol _____ Marijuana _____ Other drugs____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

____

____

Has child witnessed domestic violence? No ___Yes __ Specify:

____

____

How is your child disciplined? Please list each method and frequency of use: ___________________

____

____

Life Stressors / Trauma History:

Has your child been verbally abused? No ___ Yes ___ Suspected? Specify: ____________________

____

Has your child been physically abused? No ___ Yes ___ Suspected? Specify: __________________

____

Has your child been sexually abused? No ___ Yes ___ Suspected? Specify: ___________________

____

Other stressors or traumas such as car accidents, tragedies, or having been bullied or marginalized?
____

What are your child's strengths? ____

Childs favorite activities? ____

Child's cultural heritage?____

Child's gender identity?____

Any additional comments or information that would be helpful? ______________________________

Signature of person completing form / relationship to client:

__________________________________/__________________________________ Date: ________

Name Relationship