



## Child Intake Form

*Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your counselor will discuss your responses with you in your interview.*

To be completed by Parent/Guardian:

Child's Name \_\_\_\_\_ First Visit Date: \_\_\_\_\_

Form Completed by: \_\_\_\_\_ Relationship: \_\_\_\_\_

Child's Legal Guardian (Managing Conservator): \_\_\_\_\_

**(If the child is not living with both natural parents, both adoptive parents, or only living parent, the center requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page, stapled to this form.)**

Home Address: \_\_\_\_\_ (May receive mail: yes/no)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ (May call: yes/no; May leave message: yes/no)

Work Phone: \_\_\_\_\_ (May call yes/no; May leave message: yes/no)

Cell Phone: \_\_\_\_\_ (May call yes/no; May leave message: yes/no)

Would you like to receive a discreet phone call to remind you of your appointment 24 hours in advance?

Yes  No If, yes, I prefer the following telephone number to be used:  Home  Work  Cell

Email Address: \_\_\_\_\_ (May email: yes/no)

Can we email you our newsletter or information about any upcoming seminars?  Yes  No

Child's Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

School: \_\_\_\_\_ Grade: \_\_\_\_\_

School Counselor: \_\_\_\_\_

Name of Person(s) to contact in case of Emergency:

1. \_\_\_\_\_ Phone: \_\_\_\_\_

2. \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

*Immediate Family Members* (parents, siblings)

*Family of Origin* (extended family)

| Name | Age | Relationship | Name | Age | Relationship |
|------|-----|--------------|------|-----|--------------|
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Does anyone in your family suffer from alcoholism, and eating disorder, depression or anything that might be considered a mental disorder? Please explain: \_\_\_\_\_

\_\_\_\_\_

**\*MEDICAL INFORMATION\***

Primary Care Physician: Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Has your child ever seen a mental health professional (psychiatrist, psychologist or counselor)? Yes/No

Previous Mental Health Professional/Agency: \_\_\_\_\_

Phone: \_\_\_\_\_ Dates of Service: from \_\_\_/\_\_\_ to \_\_\_/\_\_\_

Has your child ever been hospitalized for mental health concerns? Yes/No

Please circle the following items for which a diagnosis has been given: Depression, ADHD-Hyperactive, ADHD-Inattentive, Conduct Disorder, Learning Disability, Anxiety/Nervousness, Panic Attack, Bipolar, Schizophrenia, Oppositional Defiant Disorder, Mood/Anger, Tics, Insomnia/Sleeplessness, Obsessive/Compulsive, Addictions, Post Traumatic Stress Disorder, Other: \_\_\_\_\_

List medications child is currently taking:

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Please provide a brief description of why you are seeking counseling/therapy services for your child:

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Has anything happened that may have brought on/intensified your child's problems? Yes/No. If yes, please explain:

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When did your child first begin to experience these problems? \_\_\_\_\_

How often does your child experience these problems? Check the one that best describes your child's current experience:

- Most of the day, every day
- Some part of the day, every day
- Most of the day on most days
- Some part of the day on most days
- More than once a week
- More than once a month
- Other \_\_\_\_\_

How much is/are the problems affecting your child?  Mildly  Moderately  Severely

In what areas do your child's problems impact his/her life? (Check all that apply)

- Lifestyle (the way your child lives his/her life)
- Activities (things your child normally does or would like to do)
- Relationships (your child's ability to form or maintain relationships with others)
- Eating
- Sleeping
- Mood

My child's sources of satisfaction:

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My child's sources of stress:

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My child's leisure activities:

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My child's typical day:

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Briefly describe any significant event in your child's development (including physical, psychological, emotional, intellectual, social, spiritual, and academic): \_\_\_\_\_

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**\*CURRENT CONCERNS\***

Indicate severity of the following items (1-mild; 2-moderate; 3-severe). Circle any items that you see as very significant.

- Adjustment to life changes (parents' divorce, move, loss/death of someone close, etc.)
- Bed wetting
- Abuse (physical, emotional, or sexual)
- Aggressiveness
- Anger
- Behavior problems
- Disturbing memories (past abuse, neglect or other traumatic experience)
- Drug or alcohol use (both legal and illegal drugs)
- Eating problems (purging, bingeing, overeating, hoarding, severely restricting diet)
- Excessive Behaviors (spending, gambling, etc.)
- Family or Step-family relationship
- Fears or Phobias
- Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, etc.)
- Feeling angry or irritable
- Feeling guilty or shameful
- Feeling sadness or depression or suicidal urges related to grief
- Feeling sadness or depression or suicidal urges NOT related to grief
- Health concerns (physical complaints and/or medical problems)
- Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
- Learning/Academic difficulties
- Loneliness
- Making/keeping friends
- Non-family relationship (friend, teacher, etc.)
- Personal Growth (no specific problem)
- Religious or Spiritual concerns
- Self esteem problems
- Self injurious behaviors
- Sexual problems/behavior
- Sexual identity concerns
- Sleep problems (nightmares, sleeping too much or too little, etc.)
- Significant other relationship
- Social skills or support
- Stress
- Thoughts of hurting self or others
- Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
- Unusual experiences (loss of periods of time, sensing unreal things, etc.)

**\*IMPACT OF PROBLEM ON FAMILY\***

Read each of the items below. Write in the number that corresponds with the level of impact your child's problem has in each area.

- 0 No impact
- 1 Slight impact
- 2 More than slight impact, but less than moderate
- 3 Moderate
- 4 More than moderate
- 5 Serious impact

|                                                             |                                                                       |
|-------------------------------------------------------------|-----------------------------------------------------------------------|
| 1. Time mother spends with the other children in the family | 11. Visiting friends in their homes                                   |
| 2. Time father spends with the other children in the family | 12. Emotional well being of mother                                    |
| 3. Amount of time mother spends with father                 | 13. Emotional well being of father                                    |
| 4. Amount of time father spends with mother                 | 14. Emotional well-being of brother(s) and sister(s)                  |
| 5. Family time spent with relatives                         | 15. Family finances                                                   |
| 6. Going out to eat as a family                             | 16. Relationship between parents                                      |
| 7. Going out as a family other than to eat                  | 17. Relationships among the children of the family                    |
| 8. Going on a family vacation                               | 18. Relationship between child and parents                            |
| 9. Having friends visit our home                            | 19. Relationship between parents and the other children of the family |

|               |                                    |
|---------------|------------------------------------|
| 10. Mealtimes | 20. Spending leisure time together |
|---------------|------------------------------------|