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CHILD INTAKE FORM

Thank you for taking the time to complete this form. The information and history you provide to me about your child will help me gain a better understanding of your child and help me to evaluate him/her. Please answer all questions and ask about any question you don't understand.

Today's Date: _____

How did you hear about me? Circle one:

Family member Friend Internet Insurance Child Advocacy Center
Other Therapist Doctor Brochure Attorney Department of Human Services

Other: _____

Indentifying Information

Child's Name: _____ Date of Birth: _____
Age: _____ Sex: _____ Race: _____ Religion: _____
School: _____ Teacher: _____ Grade: _____

Poor attendance Learning disabilities Poor grades Detention Suspension Fighting
Does your child experience any of the following at school? Please Circle.

Lack of Friends Behavior Issues Bullying Drugs/Alcohol Poor Concentration
Other: _____

Parent/Guardian Name: _____ Date of Birth: _____
Age: _____ Sex: M or F Race: _____ Religion: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ Okay to leave a message? Y or N
Cell Phone Number: _____ Okay to leave a message? Y or N
Work Phone Number: _____ Okay to leave a message? Y or N
Occupation: _____ Place of Employment: _____
Marital Status: _____

Parent/Guardian Name: _____ Date of Birth: _____
Age: _____ Sex: M or F Race: _____ Religion: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ Okay to leave a message? Y or N
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Work Phone Number: _____ Okay to leave a message? Y or N
Occupation: _____ Place of Employment: _____
Marital Status: _____

Family Composition

Name	Age	Date of Birth	Relationship	How well do they get along with other family members?

Does your child live in another household? If yes, please list the family members he/she lives with to the best of your ability.

Name	Age	Date of Birth	Relationship	How well do they get along with other family members?

Medical History

Child's primary care provider: _____

Medications child is currently taking: _____

_____

Has the child previously attended therapy? Y or N

Who did the child see? _____

Reason child was seen in therapy: _____

Type of therapy child received: _____

Was the therapy helpful? Circle one: Helpful Somewhat helpful Not helpful

Has your child experienced any of the following? Please circle and describe.

-chronic illness: _____

-surgeries: _____

-hospitalizations: _____

-high fevers: _____

-head injuries: _____

-seizures: _____

-eating problems: _____

-sleeping problems: _____

-encopresis/enuresis: _____

-problems with coordination: _____

-other: _____

Birth History

Is this your biological child? Y or N

If no, is this child adopted? Y or N

If yes, how old was the child when adopted? _____

If yes, does child know they were adopted? _____

Was the child's pregnancy planned? Y or N

Was the child born preterm, on time, or overdue? _____

Did the child or mother experience any problems during pregnancy? Y or N

If yes, please explain: _____

_____

Did the child or mother experience any complications during delivery? Y or N

If yes, please explain: _____

_____

Did the mother experience any depression after the baby's birth? Y or N

If yes, please explain: _____

_____

Current Stressors

Please circle any of the stressors your child has experienced over the last 12 months:

Death of a parent	Divorce of parents	Separation of parents
Remarriage of parents	Death of a family member	Death of a friend
Personal injury or illness	Parental job loss	Sexual abuse (self)
Sexual abuse (family member)	Change in family member's health	Birth of a sibling
Alcohol/drug addiction in family	Change in financial status (parents)	Vacation
Change in living condition	Change in residence	Change of school

Other: _____

_____

_____

Please describe why you are seeking therapy for your child at this time: _____

_____

_____

_____

How long have you been concerned for your child? _____

_____

What do you think the cause is of your concern? _____

_____

How have you tried to help your child so far? _____

_____

_____

Has your child ever tried to hurt or kill themselves? Y or N

If yes, please describe: _____

_____

_____

If yes, when did this occur? _____

What kind of discipline is used in your home? _____

_____

_____

Please circle all behaviors that apply to your child:

Accident prone	Aggressive	Argumentative	Bossy
Breaks the rules	Bullies others	Bullied by others	Cheats
Complains often	Conflict with parents	Conflict with peers	Conflict with siblings
Cries easily	Dawdles	Daydreams	Defiant
Destructive	Disruptive	Easily Frustrated	Fearful
Fidgety	Fighting	Finger sucking	Fire setting
Hair chewing/pulling	Head banging	Hitting	Hyperactive
Imaginary friends	Inattentive	Interrupts	Irritable
Isolates self	Lacks boundaries	Legal difficulties	Lethargic
Lies	Manipulative	Masturbates	Moody
Nail biting	Nervous/anxious	Nightmares	Noncompliant
Oppositional	Physical complaints	Poor concentration	Provokes others
Rages	Repetitive movements	Runs away	Self-harm
Sexual concerns	Shy/timid	Speech difficulties	Steals
Stubborn	Swears	Temper tantrums	Tics
Uncooperative	Under-active	Unhappy	Violent
Withdrawn	Other: _____		

Which of the above behaviors are the most concerning to you? _____

_____

Is there any other information that would be important for me to know about your child?

_____

_____

_____

_____

_____

Signature of Parent: _____ Date: _____

Signature of Therapist: _____ Date: _____