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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 each item carefully and ask question is something is not clear.

Today's Date: _____

How did you hear about me? Circle one:
☐ Family member ☐ Friend ☐ Internet ☐ Insurance ☐ Child Advocacy Center
☐ Other therapist ☐ Doctor ☐ Department of Human Services ☐ Attorney
Other: _____

Indentifying Information

Child's Name: _____ Date of Birth: _____
Age: _____ Sex: _____ Race: _____ Religion: _____
School: _____ Teacher: _____ Grade: _____
Does your child experience any of the following at school? Please Circle.
☐ Poor attendance ☐ Learning disabilities ☐ Poor grades ☐ Detention ☐ Suspension ☐ Fighting
☐ 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: _____

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Family Composition

Name	Age	Date of Birth	Relationship	How do they get along?

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 do they get along?

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- ☐ Withdrawn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

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: _____