CHILD INTAKE FORM

FAMILY

1.Child's Name_____ Sex_____ Age_____ DOB_____

2.Biological Child Yes / No If adopted, what age? _____ Foster since _____

3.Parent's Names (include step-parents, foster parents, etc.)

_____

4.Comments about custody and visitation (if applicable):

_____

_____

Brothers and Sisters

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

SCHOOL HISTORY

1.Present School: _____ Grade: _____ Teacher: _____

2.Has child ever repeated any grade? _____

3.Is child on an IEP or 504 plan? _____

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

_____

_____

SYMPTOM/PROBLEM CHECKLIST

Primary reason you are concerned about your child?

_____

_____

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

a.
_____ Sleep problems
_____ Lack of interest in activities
_____ Unassertive
_____ Fatigue/low energy
_____ Concentration problems
_____ Appetite/weight changes
_____ Withdrawal

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

b.
_____ Forgetful/memory problems
_____ Short attention span
_____ Aggressive behavior
_____ Can't sit still
_____ Not interested in peers
_____ Picked on / bullied by peers

_____ Talks excessively / interrupts
_____ Easily distracted
_____ Irritable
_____ Impulsive
_____ Difficulty following rules
_____ Problem completing schoolwork

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

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

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

_____ 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

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1.Pregnancy

Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____

Delivery: Normal _____ Breech _____ Cesarean _____ Transectional _____

Full-term _____ Premature _____ If premature, number of weeks _____

Problems at birth: (e.g., infant given oxygen, blood transfusion, incubator, etc.)

_____

2.Developmental History

- State approximate age when child did the following:

  Walked alone _____ Said first word _____ Used 2-word phrases _____

  Understood and followed simple directions _____

  Reasonably well toilet trained _____

- Did child cry excessively? _____ Rarely cried? _____

3.Health History of Child

In the first 2 years, did your child experience: _____ separation from mother

_____ out of home care _____ disruption in bonding _____depression of mother

_____ abuse _____ neglect _____ chronic pain _____chronic illness _____ parental stress

- Child's doctor: _____
- Date of last physical exam: _____
- Vision problems? Yes _____ No _____ Hearing problems? Yes_____ No_____

- Dental problems? Yes _____ No _____
- Any head injuries or loss of consciousness? Yes_____ No _____
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No _____ Yes – describe and give dates _____
- Is your child currently taking any medications? No _____ Yes _____

  List medications: _____
- List any medicines previously used for emotional problems: _____

  Were they helpful? _____
- List any allergies (including: drugs or medicines, foods, environmental conditions, etc.) _____
- Are there any foods you limit or do not give your child? No _____ Yes _____

  _____
- Does anyone in the household smoke? No _____ Yes _____
- About how many hours does this child watch TV, videos, etc. per day? _____
- Any previous counseling 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 _____

<u>Family History:</u>

- 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 (e.g., depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, ADHD, etc.):

_____

_____

Has child witnessed domestic violence? ____Y ____N Specify: _____

_____

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

_____

LIFE STRESSORS/TRAUMA HISTORY

1.Has your child been verbally abused? ____Y ____N ____ Suspected. Specify: _____

_____

2. Has your child been physically abused? ____Y ____N ____ Suspected. Specify: ___

_____

3. Has your child been sexually abused? ____Y ____N ____ Suspected. Specify: ____

_____

4.Other stressors or traumas? _____

_____

What are your child's strengths? _____