

Child Intake

Child's name _____ Today's Date _____
Child's birth date _____ Age _____ Sex _____ School attending _____
Grade _____ Religion _____ Race _____
Address _____ Length at address _____

Biological Mother's name _____ Age _____ Phone # _____
Race _____ Marital Status _____ When married/divorced/separated? _____
Address _____ Employer _____

Biological Father's name _____ Age _____ Phone # _____
Race _____ Marital Status _____ When married/divorced/separated? _____
Address _____ Employer _____

Who does child currently live with? List names, ages and relationship of people in home

Describe the child's relationship with siblings _____

Describe the child's relationship with their biological father _____

Describe the child's relationship with their biological mother _____

Describe the child's relationship with any step-parents _____

If parents are separated/divorced, what was the child's response? _____

If custody situation, please check one joint sole, with which parent? _____

If biological parents are separated or divorced, what is the visitation situation? _____

If parents are separated/divorced, how is the current relationship with each other- civil, conflictual, etc.? _____

Presenting Problem- What's going on? Why are you seeking counseling at this time?

Does your child have any of the following issues?

- | | | |
|---|---|--|
| <input type="checkbox"/> Night terrors | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Stammering | <input type="checkbox"/> Persistent Fears, Anxiety |
| <input type="checkbox"/> Low self esteem | <input type="checkbox"/> Overweight | <input type="checkbox"/> Underweight |
| <input type="checkbox"/> Frequent illness | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Frequent Family Moves |
| <input type="checkbox"/> Self Abuse | <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Preoccupation with sex |
| <input type="checkbox"/> Sexually active | <input type="checkbox"/> Excessive shyness | <input type="checkbox"/> Generally Unhappy |
| <input type="checkbox"/> Trouble with friends | <input type="checkbox"/> Depression | <input type="checkbox"/> Delinquency from school |

What do you hope to get out of counseling?

Emotional/Behavioral-

Rate the effect of your child's problems or emotional distress in each of the following areas:

	0 None	1-3 Mild	4-7 Moderate	8-10 Severe
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health/Physical well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social and Developmental History-

Is your child able to make friends? _____

How would you describe your child's personality and temperament? _____

Does your child have any developmental delays? _____

Is there a history of abuse, trauma, or loss? If yes, please describe _____

Child's strengths, interests, accomplishments _____

Daily Living Skills- does your child bath, eat, and dress themselves appropriately? _____

Education-

Is your child on an IEP? What is their relationship with their teacher? Are they involved in extracurricular activities? How are their grades? Any concerns? _____

Medical History/Problems-

List any allergies, and significant medical problems your child has now or has had in the past

If your child is on any medication- please list name, dose and reason they are taking it _____

Doctor's Name _____ Phone # _____ Date of last visit _____

Has your child been in counseling before? If so, who with and what was the outcome?

Alcohol/drug history-

Has your child used drugs or alcohol? Were they exposed to drugs or alcohol in utero ?

Legal Issues-

Is your child involved in a custody battle, are they a crime victim, are they involved in a court case regarding issues of abuse, are they in state custody or foster care? _____

Parental Issues-

Have any parents recently quit a job, got a new job, or are experiencing stress at work?

Is there marital distress between parents child lives with? _____

Are any parents involved in a legal battle, in jail, on probation, etc.? _____

Do any parents currently use drugs/alcohol? _____

Family Issues-

Are siblings going through changes/stress? _____

Is extended family experiencing changes/stress- grandparents, aunts, uncles, cousins, etc.? _____

Any thing else you would like your child's counselor to know? _____

