



**FRIENDS OF THE FAMILY  
MINISTRIES**

**Child Intake Form**

**505 NW Harrison Blvd.  
Corvallis, OR 97330  
(541) 757-1761**

**Nichole Hoffman, MS NCC**

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? \_\_\_\_\_

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