CHILD INTAKE FORM

CENTER FOR COUNSELING & FAMILY RELATIONSHIPS

Child Name: _____ Counselor Name: _____

Section 1: Checklist of Concerns-

Please mark all items below that concern you about your child:

- ❑ Accident prone
- ❑ Affectionate
- ❑ Aggressive
- ❑ Breaks rules
- ❑ Bullied by others
- ❑ Bullies others
- ❑ Clowns around
- ❑ Competitive
- ❑ Complains
- ❑ Complains of feeling sick
- ❑ Compliant
- ❑ Concern for others
- ❑ Cries easily
- ❑ Cruel to others
- ❑ Daydreams
- ❑ Defiant
- ❑ Dependent
- ❑ Depressed
- ❑ Destructive
- ❑ Difficulty w/ parental figure
- ❑ Disobedient
- ❑ Disrupts family activities
- ❑ Distractible
- ❑ Dropping out of school
- ❑ Eating issues
- ❑ Fantasy life
- ❑ Fearful
- ❑ Feelings easily hurt
- ❑ Fidgety
- ❑ Finger sucking
- ❑ Gender or sexual identity questions
- ❑ Grades
- ❑ Head banging
- ❑ Hitting
- ❑ Hyperactive
- ❑ Illness
- ❑ Imaginary playmates
- ❑ Immature
- ❑ Inappropriate sexual behaviors
- ❑ Inattentive
- ❑ Independent
- ❑ Insults others
- ❑ Interrupts
- ❑ Intolerant
- ❑ Irritable
- ❑ Isolates
- ❑ Lacks organization
- ❑ Lacks respect for authority
- ❑ Lethargic
- ❑ Loss of friends
- ❑ Lying
- ❑ Manipulates
- ❑ Mood swings
- ❑ Mute
- ❑ Nail biting
- ❑ Need for high degree of supervision
- ❑ Negativity
- ❑ Nightmares
- ❑ Noisy
- ❑ Obedient
- ❑ Obesity
- ❑ Only younger playmates
- ❑ Outgoing
- ❑ Poor concentration
- ❑ Pouts
- ❑ Procrastinates
- ❑ Provokes others
- ❑ Relationships with friends
- ❑ Relationships with siblings
- ❑ Relationships with caregivers
- ❑ Relationships with teachers
- ❑ Responsible
- ❑ Restless
- ❑ Rocking or other repetitive movements
- ❑ Runs away
- ❑ School avoiding
- ❑ Self-harming behaviors
- ❑ Sexually active
- ❑ Sports
- ❑ Spiritual values differ from caregiver
- ❑ Stealing
- ❑ Substance abuse
- ❑ Suicidal talk or attempt
- ❑ Swearing
- ❑ Temper tantrums
- ❑ Thumb sucking
- ❑ Tics
- ❑ Timid
- ❑ Vandalism
- ❑ Violent
- ❑ Wetting/soiling of bed or clothes

Look back over the concerns you have checked above. Identify your top three concerns below.

1. _____ 2. _____

3. _____

Section 2: Life Experiences-

Please check the life experiences below that apply to your child:

- ❑ Abuse – emotional
- ❑ Abuse – physical
- ❑ Abuse – sexual
- ❑ Adopted
- ❑ Bullied
- ❑ Death or loss of someone close
- ❑ Divorce
- ❑ Domestic violence
- ❑ Family member in jail/prison
- ❑ Foster care
- ❑ Injury or illness
- ❑ Injury or illness of caregiver
- ❑ Medical or mental health concerns of caregiver
- ❑ Multiple times moving
- ❑ Multiple schools
- ❑ Natural disaster survivor
- ❑ Neglect
- ❑ Parental figure loss of job
- ❑ Raised by caregiver other than biological parent
- ❑ Separation from parental figure for any time period

Section 3: Caregiver Information-

1. Please mark each of the living situations the child has experienced with the maternal figure.

- ❑ Single
- ❑ Living with partner
- ❑ Married
- ❑ Divorced
- ❑ Separated
- ❑ Widow

2. Please mark each of the living situations the child has experienced with the paternal figure.

- ❑ Single
- ❑ Living with partner
- ❑ Married
- ❑ Divorced
- ❑ Separated
- ❑ Widow

3. Do you share custody or conservatorship of your child with anyone else? YES NO

If **YES**... Name: _____

Relationship: _____

If **YES,** please mark below the best description of the co-parenting relationship.

- ❑ Cooperative
- ❑ Neutral
- ❑ Conflictual

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Section 4: Emergency Contact-

In the event of a medical emergency during a session, please contact:

Name: _____

Phone Number: _____ Relationship: _____

Section 5: School Information-

Child's School: _____ Grade: _____

Section 6: Household Information-

Please list the **Names**, **Roles** (mother, father, spouse, partner, girlfriend, boyfriend, child, stepchild etc.), and **Date of Birth** of each person who resides in the home with your child.

1. Name: _____ Role: _____

Date of Birth: _____/_____/_____

2. Name: _____ Role: _____

Date of Birth: _____/_____/_____

3. Name: _____ Role: _____

Date of Birth: _____/_____/_____

4. Name: _____ Role: _____

Date of Birth: _____/_____/_____

5. Name: _____ Role: _____

Date of Birth: _____/_____/_____

Section 7: Spiritual History-

1. Are there spiritual beliefs and practices your family follows that would be helpful for me to know about while providing counseling to your child?

_____

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Section 8: Medical History-

1. Primary Care Physician: _____ Phone # _____

2. When was your child's last physical exam? _____

3. Has your child attended counseling or been hospitalized for a mental health concern in the past? YES NO

   If **YES**, please specify the year(s) and for what reason.

   Year(s): _____ Reason: _____

4. Is child currently under the care of a psychiatrist? YES NO

   If **YES**... Name of Psychiatrist: _____

   Practice Name: _____

5. In the table below, please list any prescription, psychotropic, or over-the counter medications your child currently takes.

Name of Drug	Reason for Taking It	Date Started	Frequency Taken	Dosage	Has it been Helpful?
					0 YES 0 NO
					0 YES 0 NO
					0 YES 0 NO
					0 YES 0 NO
					0 YES 0 NO

Describe any side effects that you find troublesome from any of the medications your child is currently taking.

Section 8: Medical History (Continued)-

6. List any past or present medical conditions your child has been treated for.

_____

_____

7. Have you noticed or has your child been assessed for:

Developmental delays: _____

Difficulty with coordination: _____

Learning disability: _____

If **YES** to any of the above, please explain:

_____

_____

8. How many hours does your child exercise a week?

_____

9. How many hours does your child sleep at night?

_____

10. How much caffeine does your child consume in a day?

_____

11. How many times does your child eat out each week?

_____

12. How many hours of screen time does your child have each week?

_____