Child Intake Form

Child's Name:________________________________ Sex:________ Age: _______ DOB:__________

Natural Child: Yes / No   If adopted, at what age:________________ Foster Since:____________

Parent's Names: (Please include step-parents, foster parents, etc.)_________________________

____

____

Comments about custody and visitation: (if applicable) ___________________________________

____

____

Primary reason you are concerned about your child:________________________________

____

____

What are the goals in therapy? ____

____

____

Symptom/Problem Checklist

Please check any symptom that is a concern, and list how long it has been a problem.

- ☐ Sleep Problems ____________
- ☐ Lack of Interest in Activities ____________
- ☐ Unassertive ____________
- ☐ Fatigue/Low Energy ____________
- ☐ Concentration Problems ____________
- ☐ Appetite/Weight Changes ____________
- ☐ Withdrawal ____________
- ☐ Forgetful/Memory Problems ____________
- ☐ Short Attention Span ____________
- ☐ Aggressive Behavior ____________
- ☐ Can't Sit Still ____________
- ☐ Not interested in peers ____________
- ☐ Picked on/Bullied by peers ____________
- ☐ Excessive worry/fearfulness ____________
- ☐ Anxiety/panic attacks ____________
- ☐ Social fears/shyness ____________
- ☐ Separation problems ____________
- ☐ Morbid thoughts ____________
- ☐ Suicidal thoughts or threats ____________
- ☐ Suicidal plans/attempts ____________
- ☐ Mood swings ____________
- ☐ Depression ____________
- ☐ Changed level of activity ____________
- ☐ Cries easily ____________
- ☐ Talks excessively/interrupts ____________
- ☐ Easily disturbed ____________
- ☐ Irritable ____________
- ☐ Impulsive ____________
- ☐ Difficulty following rules ____________
- ☐ Problem completing schoolwork ____________
- ☐ Nightmares ____________
- ☐ Frequent tantrums ____________
- ☐ Resistive to change ____________
- ☐ School refusal ____________

☐ Bedwetting/soiling	☐ Perfectionism
☐ Headaches and/or Stomachaches	☐ Odd hand/motor movements
☐ Odd beliefs/fantasizing	☐ Hallucinations
☐ Lying	☐ Stealing
☐ Trouble with the law	☐ Being destructive
☐ Running away	☐ Fire setting
☐ Truancy/skipping school	☐ Hurting others/fighting
☐ Hurting others sexually	☐ Acts as if he/she has no fear
☐ Alcohol/drug use	☐ Short tempered
☐ Argumentative/defiant	☐ Easily annoyed/annoys others
☐ Swearing	☐ Discipline Problem
☐ Blames others for mistakes	☐ Angry and resentful

Siblings Name(s)	Sex	Age	Relationship to Child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

School History

Current School:________________________________ Grade:______ Teacher:____________________

Has your child repeated any grade levels? ____

Is your child in special education services?_________If so, which kind?______________________

Please describe any problems (academic/other) that your child has experienced at school.

____

____

Development and Medical History

Fetal & Infant Development

During pregnancy did mother use? Alcohol:_____ Drugs:_____ Cigarettes:_____ N/A:_____

Delivery Normal:_____ Breech:_____ Cesarean:_____ Transectional:_____

Full term:_____ Premature:_____ Premature, how many weeks?_____

Birth weight:__________

List any problems/complications at the time of birth (infant given oxygen, blood transfusion, incubator)

____

____

Please list the approximate age at which your child did the following:

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

Understood and followed simple directions: _____ Reasonably well toilet trained: _____

Did your child cry excessively: _____ Rarely:_____

Early Development and Health History

In the first two years, did your child experience any of the following:

Separation from mother: _____ Out of home care: _____ Disruption in bonding: _____

Depression of mother: _____Abuse: _____Neglect:_____ Chronic Pain:_____

Parental Stress: _____

Child's Primary Doctor:____

Date of last physical examination:____

Vision Problems: Yes:_____ No:_____ Hearing Problems: Yes:_____ No:_____

Dental Problems: Yes:_____ No:_____ Head injuries/Loss of consciousness: Yes:_____ No:_____

Does your child have a history of serious illness, injury, handicaps, or hospitalization?

Yes:_____ No:_____ If yes, please describe and provide dates:____________________

____

____

Please list all medication(s) that your child is currently taking:___________________

____

____

List any medications that have previously been used to treat emotional problems: did it help?

____

____

Allergies to drugs/medicines? Yes: _____ No: _____ (List)______________________________

Allergies to any foods? Yes: _____ No: _____ (List) ____

Are there any foods that you limit or do not give to your child? Yes: _____ No: _____

(List) ____

Allergies to environmental conditions? Yes: _____ No: _____ (List)___________________________

Does anyone in your household smoke? Yes: _____ No: _____

Approximately how many hours does he/she spend watching TV/Playing Videogames? _____

Are you afraid someone you know may injure/harm your child? Yes: _____ No: _____

Call 911 or Child Protective Services (970) 542-3530

Has your child received previous psychological or psychiatric treatment? Yes: _____ No: _____

Preivious provider name/practice: ______________________________ Date: ________________

Has your child had any previous testing? (School/Psychological) Yes: _____ No: _____

Whom/Where was the test conducted: _________________________ Date: ______________

Do you think your child's use of chemicals is a problem? Yes: _____ No: _____ NA: _____

Alcohol: _____ Marijuana: _____ Other Drugs: ____

Comments: ____

____

Family History

Parental chemical use (now & past): Yes: _____ No: _____ Which parent: ____________________

Alcohol: _____ Marijuana: _____ Other drugs: ____

List any history of mental illness or addiction in immediate or extended family (Depression, anxiety, bi-polar or manic-depressive disorder, suicide attempts, alcoholism, drug abuse, ADHD, schizophrenia, etc.)

____

____

Has your child witnessed domestic violence? Yes: _____ No: _____ Specify:___________________

____

How is your child disciplined? Please list all methods and frequency of use: ___________________

____

____

Stressor/Trauma History

Has your child been verbally abused? Yes: _____ No: _____ Suspected: _____ Specify: __________

____

Has your child been physically abused? Yes: _____ No: _____ Suspected: _____ Specify: ________

____

Has your child been sexually abused? Yes: _____ No: _____ Suspected: _____ Specify: _________

____

____

Please list any other stressors or traumas: ____

____

____

What are your child's strengths? ____

____

Who and/or what are your child's & family's support network? ___________________________

____

Additional Comments: (any information that would be helpful for us to know) ______________________

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____

____

____ ____________________

Signature of person completing the form Date

____ ____________________

Printed Name Relationship to Client