CHILD CLIENT INTAKE FORM

Rachel Finch Sulka, M.S. MFT
Licensed Marriage and Family Therapist #51499
(805) 364-4427

Client Name:_____ DOB:_____

Address:_____

Phone number:_____ Email:_____

Employer:_____

Employer address:_____

Employer phone:_____

School:_____ School Phone:_____

School address:_____

Child and Family History

Form completed by: { } Parent { } Foster Parent { } Guardian { } Other :_____

Are you a single parent? { } Yes { } No

Child's Name: _____ DOB: _____ Age: _____

Gender: { } Male { } Female Grade: _____ Name of School: _____

Referred by: { } Parent/Guardian { } Pediatrician { } School { } Self { } CWS { } Social Services { } Court Order { } Other: _____

Address: _____ City: _____ Zip Code: _____

Telephone: H _____ W _____ Cell _____

Parent's Email Address: _____

Therapist may leave message at : { } Home { } Work { } Cell { } Email (Preferred:_____)

Emergency contact person: _____

Relationship: _____ Phone #: _____

****

Type(s) of service desired: { } Child therapy { } Adolescent therapy { } Family therapy

{ } Group Therapy { } Referral for medication evaluation

Child's main problem/major reason for seeking help at this time: _____

_____

_____

_____

_____

How long has your child had these problems, symptoms, or issues? _____

_____

_____

Has your child had treatment for these issues in the past? { } Yes { } No

If Yes, was the outcome helpful? { } Yes { } No

Has your child had inpatient mental health treatment? { } Yes { } No

Briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome:

_____

_____

_____

Describe any other behavioral or emotional problems your child is having: _____

_____

_____

_____

Describe the impact of your child's problems on the family: _____

_____

_____

Describe your child's strengths and unique qualities: _____

_____

_____

Is your child currently under the care of a physician or psychiatrist? { } Yes { } No

If yes: Doctor's Name: _____ Phone # _____

Treatment for: _____

Is your child currently taking any medications? { } Yes { } No If yes, include the following information:

Name of medications Dosage Prescribed by

_____ _____ _____

_____ _____ _____

_____ _____ _____

Does this child have a history of abuse (physical, sexual, emotional, neglect)? { } Yes { } No

If yes, please describe briefly, including dates, location, perpetrators, type of abuse and impact on child/family:_____

_____

_____

_____

Is there legal action pending related to accusations of abuse? { } Yes { } No

If yes, describe briefly: _____

_____

_____

_____

Is there any other legal action that may have impacted your child? Please check all that apply:

Current or Past

Custody Visitation

Adoption Child Protective Services

Probation Other

If yes, describe briefly: _____

_____

_____

BEHAVIOR CHECKLIST :

Please check any of the following behaviors that concern you:

Behavior	Past	Present	Behavior	Past	Present
Crying, sadness, depression			Argues a lot		
Temper outbursts			Disobedience		
Loss of enjoyment of usual activities			Bedtime fears		
Irritability, anger			won't sleep		
Expressing a wish to die			Does things that annoy others		
Has threatened/attempted suicide			Worries more than others		
Panics			Unusual fears or phobias		
Anxious, nervous			Repeats unnecessary act over and over		
Is overly concerned about things			Is overly concerned about things		
Has rituals, habits, superstitions Twitches or unusual movements			Eats very little/fasts to lose weight		
Gorges or binge eats			Sleepwalking		
Blames others for own mistakes			Withdrawn Easily		
Annoyed by others			Nightmares, night terrors		
Swears or uses obscene language			Low self-esteem		
Wanting to run away			Wakes up very early		
Unable to go back to sleep			Sneaks out at night		
Tiredness, fatigue			Injures self		
Restless sleep			wakes frequently		
Trouble going to sleep			Stealing		
Sleeps too much			Lying		
Poor appetite			Hurts animals		
Under or overweight			Destroys property		
Over-activity			Hurts people		
Frequently acts without thinking			Drug use		
Doesn't finish things			Alcohol use		
Disruptive Sexual problems			Cigarette use		
Short attention span			Problems with authority		
Daydreams, fantasizes			Problems with the law		
Easily distracted			Hallucinations		
Low motivation			Vomits intentionally		
Bedwetting/daytime wetting			Disorientation		
Soiling (pooping) in pants			Strange or unusual behavioral		

Forms of discipline used in the home: { } Time out { } Loss of privileges { } Grounding

{ } Rewards/incentives { } Extra chores { } Physical/corporal punishment

{ } Other: _____

Relationship Development Check each item that describes your child:

	Current	Past		Current	Past
Prefers to be alone			Is demanding and bossy		
Is alone a lot, but dislikes this and feels lonely			Fights with others		
Is shy			Bullies others		
Has few friends			Teases a lot		
Has many friends			Plays with younger kids		
Plays with "problem kids"			Plays with older kids		
Is picked on a lot			Poor relationships with peers		
Is oversensitive			Conflict with parents/step-parents		
Poor relationships with teachers			Has difficulty getting along with brothers and sisters		

School Check any area of concern:

	Current	Past		Current	Past
Dislikes school			Missed many school days		
Works hard but does not do well			Repeated a grade		
Unmotivated, refuses to complete work			Discipline referrals, detentions		
Learning problems			Suspensions (how many? ___)		
Expulsions (how many? _____)					

If your child has been suspended or expelled, please explain: _____

_____

_____

_____

School Environment Check all that apply:

	Current	Past		Current	Past
Resource classes/special ed.			Continuation school		
Gifted program			Home study		
Speech therapy			Independent study		
Other programs					

If other programs, please explain: _____

_____

_____

Family Stresses Check all that apply:

	Current	Past		Current	Past
Marital problems			Housing problems		
Marital separation			Legal issues		
Divorce Custody disputes			Death of a friend		
Financial problems			Death of a relative		
Job loss			Death of a pet		
Parents using alcohol/drugs			Family illness		
Other stressors:					

If other stressors, please describe: _____

_____

_____

Developmental History During pregnancy, did mother:

{ } drink { } drugs { } illness { } accident

{ } problems with pregnancy { } problems with labor { } problems with delivery

If yes, please describe: _____

_____

_____

Please check if child is/was delayed in any of the following areas: { } holding head up

{ } turning over { } sitting up { } crawling { } walking alone { } weaning { } feeding self

{ } toilet training { } using single words { } using sentences { } dressing self { } sleeping through night

Briefly explain any delays: _____

_____

_____

_____

As a baby/toddler, was child: check all that apply

{ } eating well { } colicky { }head banging { } performing rocking behavior { } clumsy

{ } easy to regulate (sleeping/eating) { } wanting to be left alone { }adaptable to transitions

{ } more interested in things than people { } easy to soothe { } performing daredevil behavior

Medical History Indicate if your child has had any of the following:

Condition	Yes	No	Age	Details

Serious Infection				
Convulsions/seizures				
Head injuries				
Other injuries				
Hospitalizations				
Surgeries				
Ear infections				
Poisonings				
Allergies				
Asthma				
Alcoholism				
Drug Use				
Sexual Problems				

Does your child have any other medical conditions? { } Yes { } No

If yes, please describe: _____

_____

_____

Does your child frequently complain of bodily aches and pains? { } Yes { } No

If yes, please describe: _____

_____

_____

Does your child miss school because of his/her physical complaints? { } Yes { } No

If yes, please describe: _____

_____

_____

Does your child have any allergies to medications, drugs or foods? { } Yes { } No

If yes, please describe: _____

_____

_____

Family Information: List all of the people who currently live with the child

Name	Age	Relationship	Occupation/School and Grade

What are your family supports? (church, friends, clubs etc.) _____

_____

_____

What are your family strengths? _____

_____

_____

Additional comments: _____

_____

_____

_____

Indicate if any family members or relatives have the following: Please distinguish if it's past or present.

Problem:	Father	Mother	Brother(s)	Sister(s)	Other
Problems with attention, activity or impulse control as a child					
Learning disabilities					
Did not graduate from high school					
Alcohol abuse					
Drug use					
Problems with aggressive behavior as adult or child					
Antisocial behavior (arrests, jail, legal problems, probation, other)					
Abuse victim					
Abusive to others					
Depression					
Nervous disorders					

Mental retardation					
Serious illness or surgeries					
Physical handicaps					
Tics or unusual movements					
Other mental problems or concerns					

Please list any adults who are authorized to drop off or pick up your child from his/her therapy session in the event you or another legal guardian is unavailable:

Name	Relationship to child

I authorize the above named person(s) to drop off or pick up my child from his/her therapy session. I agree that I or any person named by me (listed above) will not leave the premises and will remain in the waiting room for the duration of my child's therapy session.

_____ _____

Child's Name Date of Birth

_____ _____

Print Parent/Guardian Name Relationship to child

_____ _____

Signature Date

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

I authorize Rachel Finch Sulka to charge the credit card provided herein for purposes of copayments, deductibles, and fees not reimbursed by my insurance company, managed care organization, or third party. I understand that I am responsible for payment of all services rendered, including those which are not reimbursed by my insurance company, managed care organization, or third party. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

Return the completed and signed form to the following:

Rachel Finch Sulka

rachelfinchmft@gmail.com