CONFIDENTIAL
FOR PROFESSIONAL USE ONLY

Child Intake Form
Psychology and Counseling Associates of Carmel

Name of child_____ Date_____

Your relationship to child _____

Describe the problem with which you would like help_____

_____

_____

_____

When did the problem start_____

Have you tried to solve this problem before _____

What do you believe is the main source of the problem _____

List previous psychological or psychiatric services your child has received in the past:

Place or person Dates Outcome

_____

_____

_____

I Developmental Information

Was the pregnancy of normal duration and development _____

If not, please explain _____

Was childbirth at term and without complication _____. If not please explain _____

_____

_____

Please state whether child has past thought the normal developmental stages;

Infancy _____Crawling _____ Walking _____ Talking _____ Potty training _____

Weaning from bottle_____ Eating _____ Sleeping _____

If not please explain _____

_____

_____

_____

II Medical history:

Does your child have any diseases, conditions or allergies _____

If yes please explain _____

_____

_____

Has your child been hospitalized _____ If yes, please explain _____

_____

Is your child on medication, If yes please state (include allergies medication)

Medication Dosage Provider Reason prescribed

_____

_____

_____

_____

III Family history;

Who does the child live with: parents, siblings, etc. Please give names and ages

_____ _____

_____ _____

_____ _____

_____ _____

Have any of the immediate family members been treated for mental health problems_____

If yes, please state who and for what ; _____

_____

_____

_____

Has your child suffered:

Sexual abuse _____ Physical abuse _____ Emotional abuse _____Drug abuse _____

If yes, please state by whom and when _____

_____

_____

Is there any abuse in the family sexual, physical, alcohol or drugs (street or prescription) _____ If yes.

Please explain _____

_____

_____

IV Child's education

Present school _____ Grade_____

What age did child start school _____ Any grades repeated or skipped _____

How does your child react to school _____

What are the child's favorite subjects _____

What are child's least favorite subjects _____

V. Current Behaviors

	Yes	No
Is your child a loner	____	____
Does your child prefer younger children?	____	____
Does your child prefer older children?	____	____
Prefer adults over children ?	____	____
Afraid of adults ?	____	____
Is your child a leader?	____	____
Avoid being a leader?	____	____
Frequently fights w/ peers?	____	____
Frequently fights w/ adults (who?)	____	____
Frequently fights w/ siblings?	____	____
Is your child fearful?	____	____
Does your child engage in fantasy?	____	____
Much daydreaming?	____	____
Hallucinations?	____	____
Self destructive behavior?	____	____
Sexual activity?	____	____
Pre-occupation w/ death?	____	____
Suicidal thoughts?	____	____
Nervous habits?	____	____
Poor attention/ concentration?	____	____
Poor memory?	____	____
Difficulty solving problems?	____	____
Poor coordination?	____	____

	Yes	No
Stuttering ?	____	____
Thumb sucking?	____	____
Biting ?	____	____
No speech – refuses to talk ?	____	____
Verbal aggression ?	____	____
Physical aggression ?	____	____
Cruelty to animals ?	____	____
Lying ?	____	____
Stealing?	____	____

Other ? Please specify _____

_____

_____

_____

Space available for additional information.