

Tree of Life Counseling Services 1460 Walton Blvd Suite 60 (Main Office) Rochester Hills, MI 48309 www.treeoflifecounselingservices.com (248) 608-4514

Child Therapy Intake Form

OP.	Ασοι	Corr.	
	Age:		
ome address:			
ame of person comple	eting this form:		
	d:		
none:	Em	 ail:	
ame of other parent/l	egal guardian:		
elationship to the chil	d:		
	Em		
rothers and sisters:			
Tottlers and sisters.			
Full name	Age	Sex	Relationship to child (full, step half, adopted)
hild's Developmen	tal and Medical His	tory	
	1 1 1	11	0.77
ıd the mother use dru	gs, alcohol, or tobacco	during the pregn	ancy? Yes No

Delivery: Vaginal	Breech	Cesarean	Other	
	_Premature, if so how			
Birth weight:	Bir	th Height:		
Problems at birth	(i.e.: infant placed in	n the NICU)?		
Did your child wa Yes No _	lk, talk, and toilet tra	in on time? If no, e	xplain.	
Has your child be Yes No _	en diagnosed with ar 	ny illness? If yes, ex	plain.	
Does your child h	ave any allergies? If y	yes, explain. Yes	No	
Is your child curre	ently taking any med	ications? If yes, exp	olain. Yes	No
	of your child's medi			
Address:		Phone n	umber:	

Family History			
	Yes	No	List Family Member
ADHD			
Alcohol/Substance Abuse			
Anxiety			
Bipolar Disorder			
Depression			
Domestic Violence			
Eating Disorders			
Obesity			
Obsessive Compulsive Disorder			
Schizophrenia			
Suicide Attempts or completion			
Academic Information	l		
Name of child's school:			
Гeacher:	(Counselor:	
Grade:			
			NT -
Has your child ever repeat	ed a grader 11 yes	s, explain. Yes	NO

Does your child have a 504 Plan or an IEP? Yes No
Is your child bullied? If yes, explain. Yes No
Does your child act as a bully? If yes, explain. Yes No
Social Information
Is your child involved in any extra circular activities? If so, what?:
Does your child have friends?
Does your child use social media? If so, what do they use?
How is your child disciplined?

Stressful Life Events

	No	Yes	If yes, explain
A recent change or			
move in school?			
Abuse or neglect?			
Academic			
difficulties?			
Birth of sibling?			
Bullied?			
Death or illness of a			
loved one?			
Divorce?			
Family conflict?			
Natural disaster?			
Self-injury?			
Sexual orientation concerns?			
Other?			
Presenting Problem	1		

What is the reas	on for your chil	d's visit?		
When did this st	art?			

Has your child ever received counseling before? If so, for what?

What are your goals for your chi	ld's treatment?	
How long do you expect your chi	ild to be in therapy?	
Less than 3 months	3-6 months	
6-9 months	9 or more months	_
What are your child's positive qu	ualities and strengths?	
Is there anything else you would	l like to mention?	
	_	

Thank you for taking the time to complete this form. I look forward to working with you and your child.