CHILD INTAKE FORM

 **CHILD’S PERSONAL DETAILS**

(For Parent/Guardian to Complete)

Child’s Name:

DOB:

Age:

 Race/Ethnic Origin:

Religion:

School:

Year Group:

Parent/Caregivers Names:

Current Household and family information

(Who lives in the family home, what is the family dynamic, are there any conflicts with siblings/parents, if so please detail)

Child’s interests and hobbies:

# **CHILD’S DEVELOPMENT**

 Were there any complications with the pregnancy or delivery of your child?

 Did your child have health problems at birth?

 Did your child experience any developmental delays (e.g., toilet training, walking,talking)?

 Did your child have any unusual behaviours or problems prior to age 3?

 Has your child experienced emotional, physical, or sexual abuse?

# **HEALTH CONCERNS:**

 In general, your child’s health has been:

\_\_\_\_\_\_\_Excellent (is rarely sick when sick recovers very quickly)

\_\_\_\_\_\_\_good (is not often sick or injured, illnesses are short-lived)

\_\_\_\_\_\_\_fair (frequently sick or injured, illnesses often linger or recur)

\_\_\_\_\_\_\_poor (chronically ill)

Is your child currently on any medication?

Name of Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Surgery:

#

# **Emotional/Behavioural/Chemical Issues**

Has your child recently or currently experienced the following?

|   |  YES or NOPlease feel free to add extra info here |
| --- | --- |
| Suicide attempts |   |
| Suicide plans |   |
| Recent Suicidal thoughts |   |
| Depression |   |
|  loneliness, or hopelessness |   |
| Self-inflicted injury behaviours |   |
| Difficulty sleeping |   |
| Crying often |  |
| A tendency to be shy or sensitive |  |
| A strong dislike of criticism |  |
| Often annoyed by little things |  |
| A frequent loss of temper |  |
| Difficulty completing tasks |  |
| Difficulty expressing feelings |  |
| Violent or destructive behaviour |   |
| Nervousness, anxiety, or worry |  |
| Difficulty remembering |  |
| Difficulty relaxing |  |
| Difficulty concentrating |  |
| Difficulty making decisions |  |
| Mental Confusion |   |
| Difficulty making friends |   |
| Difficulty with eating |   |

· Has your child ever been in court or picked up by the police?

· Do you think your child has tried cigarettes, sniffing, alcohol or drugs?

# **PEER RELATIONS**

· Describe your child’s personality:

· Describe your child’s relationship with others (do they prefer to be alone, have one or two close friendships, prefer larger groups etc)

· Has your child experienced any bullying?

· Is your child involved in any organised social activities (e.g., sports, scouts, music)?

# **SCHOOL HISTORY**

· Has your child ever been held back a year?

· Does your child like school?

· Do you feel your child is doing the best he/she can at school?

· Are there any behaviour problems at school? Yes \_\_\_\_ No \_\_\_\_\_ If yes, please explain:

# DISCIPLINE

 What strategies do you use at home for behaviour management? Do you find they are working?

# INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc?

COUNSELLING HISTORY

· Has your son or daughter previously seen a counsellor?

· Approximate Dates of counselling

· For what reason did your son or daughter go to counselling?

 What did you find most helpful in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

· What did you find least helpful in therapy?

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# **Current Concerns**

· What brings you to signing your child up for counselling? What issues do you find most troubling?­­­­­

· Are there any goals that you would like your child to work on whilst they attend counselling sessions?

· Any other comments that you would like to add that you find relevant

Parent Contact Email:

Parent Phone Number:

Parent Name-

Signature

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_