Coastal Waters
COUNSELING SERVICES

Child Intake Form

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out all of this form.

Child's Name: _____ Date: _____

Age: _____ Date of Birth (DOB): _____ SS#_____

Address: _____

Child's Phone: _____

Child's Email: _____

Mother's name: _____

Birthdate: _____ S.S.#_____

Address: _____

Email: _____

Father's name _____

Birthdate: _____ S.S.# _____

Email _____

Home phone: _____ May I leave a message? ☐ Yes ☐ No

Cell phone: _____ May I leave a message? ☐ Yes ☐ No

Work phone: _____ May I leave a message? ☐ Yes ☐ No

Family Doctor: _____

Clinic: _____

Phone: _ _____

Prior Counseling? ☐ YES ☐ NO if YES, with whom: _____

Medication? ☐ YES ☐ NO if YES Please provide medication name and dosage:

_____

_____

Symptom / Problem Checklist: Check any symptom that is a concern

- ☐ 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
- ☐ Morbid thoughts
- ☐ Suicidal thoughts
- ☐ Suicidal plans / attempts
- ☐ Mood swings
- ☐ Depression
- ☐ Changed level of activity
- ☐ Cries easily
- ☐ Talks Excessively / interrupts
- ☐ Easily distracted
- ☐ Irritable
- ☐ Impulsive
- ☐ Difficulty following rules
- ☐ Problem completing work
- ☐ Excessive worry / fearfulness
- ☐ Anxiety or panic attacks
- ☐ Social fears, shyness
- ☐ Separation problems
- ☐ Bedwetting / soiling
- ☐ Headaches / Stomachaches
- ☐ Lying
- ☐ Trouble with the law
- ☐ Running away
- ☐ Truancy, skipping school
- ☐ Hurting others sexually
- ☐ Alcohol / drug use
- ☐ Argumentative / defiant
- ☐ Swears
- ☐ Blames others for mistakes
- ☐ Nightmares
- ☐ Frequent tantrums
- ☐ Resistive to change
- ☐ School refusal
- ☐ Perfectionism
- ☐ Odd hand / motor movements
- ☐ Hallucinations
- ☐ Stealing
- ☐ Being destructive
- ☐ Fire setting
- ☐ Acts as if has no fear
- ☐ Short tempered
- ☐ Easily annoyed / annoys others
- ☐ Discipline problem
- ☐ Angry and resentful
- ☐ Quick to anger

School History:

Present School: _____ Grade: _____

Has child ever repeated any grade? ☐ YES ☐ NO If yes, which grade(s)? _____

Does child receive special education services? ☐ YES ☐ NO

If yes, which kind? _____

Please describe academic or other problems your child has had in school:

_____

_____

_____

Child's Medical History:

Child's Doctor _____ Phone: _____
First Name Last Name

Clinic Address: _____
Street City State Zip

Date of last physical exam: ___ / ___ / ____ Any head injuries or loss of consciousness? ☐ Yes ☐ No

Vision problems? ☐ Yes ☐ No Hearing Problems ☐ Yes ☐ No Dental problems ☐ Yes ☐ No

Child's history or serious illness, injury, handicaps, or hospitalizations? ☐ Yes ☐ No

If yes, describe and include dates:

_____

_____

Is your child currently taking any medications? ☐ Yes ☐ No If yes, name of medication:

_____

_____

List any medications previously used for emotional problems: Were these helpful?

_____

_____

Family History:

Chemical Use (now and past) ☐ Yes ☐ No Which parent or household member? _____

☐ Alcohol ☐ Marijuana ☐ Other drugs _____

List any history of mental illness or addiction in immediate or extended family (e.g. depression, anxiety, bi-polar, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

_____

_____

Has child witnessed domestic violence? ☐ Yes ☐ No If yes, specify:

_____

Has your child been disciplined? ☐ Yes ☐ No Please list each method and frequency of use:

_____

_____

Life Stressors / Trauma History:

Has your child ever been verbally abused? ☐ Yes ☐ No Specify _____

_____

Has your child ever been physically abused? ☐ Yes ☐ No Specify _____

_____

Has your child ever been sexually abused? ☐ Yes ☐ No Specify _____

_____

List any other stressors or traumas: (e.g. death in the family, divorce, change of schools, moving etc.)

_____

_____

_____

What are your child's strengths?

- ☐ Honest / Trustworthy
- ☐ Caring / Kind
- ☐ Helpful
- ☐ Empathetic
- ☐ Loyal
- ☐ Hardworking
- ☐ Independent
- ☐ Resilient
- ☐ Cooperative
- ☐ Eager
- ☐ Curious
- ☐ Shares / takes turns
- ☐ Good listener
- ☐ Good at making friends
- ☐ Sensitive to others' needs
- ☐ Accepts differences in others
- ☐ Asks for help when needed
- ☐ Appropriate coping skills
- ☐ Resists peer pressure
- ☐ Accepts personal responsibility
- ☐ Can apologize if needed
- ☐ Likes to talk to people
- ☐ Participates in discussions
- ☐ Can change tone of voice when telling stories or asking questions
- ☐ Tells stories with clear beginning, middle & end
- ☐ Uses age-appropriate grammar
- ☐ Likes learning words in songs
- ☐ Likes listening to stories
- ☐ Can answer who, what, where, why, and how questions
- ☐ Understands jokes, puns, and sarcasm
- ☐ Can rhyme
- ☐ Enjoys reading or being read to
- ☐ Seeks out fun things to read
- ☐ Can sound out unfamiliar words
- ☐ Understands written information
- ☐ Can remember details and retell stories
- ☐ Can make predictions
- ☐ Can pause when reading & return to that sentence if interrupted
- ☐ Reads with expression
- ☐ Learns new words easily
- ☐ Gentle with animals
- ☐ Uses words to express needs, wants and ideas
- ☐ Makes connections between reading and personal experiences
- ☐ Has strong number sense
- ☐ Sees and understands patterns in nature & numbers
- ☐ Can do mental math
- ☐ Uses math concepts in real world (e.g. cut recipe in half)
- ☐ Understands math concepts in word problems
- ☐ Solves puzzles or word problems
- ☐ Likes playing games that involve strategy
- ☐ Likes taking things apart and figuring out how they work
- ☐ Sets goals
- ☐ Can plan ahead
- ☐ Self-starter
- ☐ Can ignore distractions and stay focused on tasks
- ☐ Self-advocates (asks for help)
- ☐ Can work or play independently
- ☐ Works well / gets along in groups
- ☐ Can dance, act, sing – is musical
- ☐ Likes drawing / doodling
- ☐ Enjoys entertaining people
- ☐ Does not argue with adults

Please list any additional strengths or information that would be helpful to us:

_____

_____

_____

_____

_____

_____

☐ I agree that this document has been completed to the best of my ability and knowledge.

_____ _____

Signature of Person Completing Form/Relationship to Client Date

_____ _____

Signature of Therapist Date