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**CHILD/ADOLESCENT INTAKE FORM**

1. **Name of Child:**

First name: Click or tap here to enter text.

Middle name: Click or tap here to enter text.

Last name: Click or tap here to enter text.

1. **Date of birth:** Click or tap here to enter text.
2. **Age:** Click or tap here to enter text.
3. **Name of Mother/Guardian:**

First name: Click or tap here to enter text.

Middle name: Click or tap here to enter text.

Last name: Click or tap here to enter text.

1. **Occupation of Mother/Guardian:**

Click or tap here to enter text.

1. **Name of Father/Guardian:**

First name: Click or tap here to enter text.

Middle name: Click or tap here to enter text.

Last name: Click or tap here to enter text.

1. **Occupation of Father/Guardian:**

Click or tap here to enter text.

1. **Child is:**

Biological  Adopted Foster

1. **Parents are:**

Married  Defacto  Separated  Divorced

1. **Address:** Community: Click or tap here to enter text.

Parish: Click or tap here to enter text.

1. **Telephone Numbers:** Home: Click or tap here to enter text.

Mother’s Cell: Click or tap here to enter text.

Father’s Cell: Click or tap here to enter text.

1. **Email Address(es):** Click or tap here to enter text.
2. **Referral: Where did you hear about us?** Click or tap here to enter text.
3. **Private Health Insurance (if applicable):** Click or tap here to enter text.
4. **If you have private health insurance, are you covered for psychological service?**

Click or tap here to enter text.

1. **Names and ages of siblings:** Click or tap here to enter text.

**MEDICAL HISTORY**

1. **Please tick all that apply**:

Head injury

Loss of consciousness

Epilepsy

Headaches or migraines

Frequent ear infections

Tics/Twitching

Repetitive motor movements

Echolalia, i.e., repeats what others say for no reason

Sensory issues with sensitivity to sound, light, and touch

Temper tantrums

Self-injurious behaviour

Hydrocephalus, i.e., build-up of fluid in the brain

Asthma

Allergies

Intellectual delay

Development delay

None

Other: Click or tap here to enter text.

1. **Please describe the above or other medical issues in more depth, ensure to list any illnesses, hospitalization, or medical conditions:**

Click or tap here to enter text.

1. **List all medications: Names & dosages (Note whether current or previous):**

Click or tap here to enter text.

1. **List any supplementation taken regularly, eg. Iron, zinc magnesium, Omega 3 etc.**

Click or tap here to enter text.

**DEVELOPMENTAL HISTORY**

1. **List any language spoken at home other than English**

Click or tap here to enter text.

* *Please upload any occupational therapy/speech therapy/other reports here (or bring to consultation if unable to upload)*

1. **Identification of sleep and/or energy issues. Tick all that apply:**

Problems falling asleep

Waking at night

Not enough sleep

Excessive sleep for age

Very tired upon waking and hard to get moving

Low energy during the day

High energy during the day

No issues with sleep or energy

Other: Click or tap here to enter text.

**PSYCHOLOGICAL BACKGROUND**

1. **Please describe your child's current mental state, ensure to list any issues with low mood, depression, anxiety, anger, self-esteem etc.**

Click or tap here to enter text.

1. **Has your child seen a psychologist or other mental health practitioner? Name of practitioner, year, duration, issues addressed etc.**

Click or tap here to enter text.

1. **Previous diagnoses? List name of practitioner, year of diagnosis, diagnosis given. List all diagnoses including autism spectrum, ADHD, mood disorders, behavioural disorders, learning disorders, intellectual disability, tic disorders, eating disorders, personality disorders etc.**

Click or tap here to enter text.

1. **Does your child have any behavioural issues at home? Please note issues with hitting, tantrums, aggression, defiance, not listening to instructions.**

Click or tap here to enter text.

1. **Does your child have any issues with social skills or socializing? List any issues with socializing e.g., issues making friends, keeping friends, preferring to isolate themselves, lacking empathy, doesn't seek out peers, poor social skills, poor eye contact, can't see things from others point of view, considers themselves dominant over adults and other children, controlling etc.**

Click or tap here to enter text.

1. **Does your child have any issues with attention? E.g., easily distracted, has trouble focusing, forgetful, loses belongings**

Click or tap here to enter text.

* Please upload any reports of previous reports of diagnoses (or bring to consultation if unable to upload)

1. **Family history of psychological, cognitive, learning or behavioural issues? Please list any relevant family diagnoses as well as suspected issues that appear obvious but may be undiagnosed.**

Click or tap here to enter text.

**EDUCATIONAL BACKGROUND**

1. **Name of school:** Click or tap here to enter text.
2. **Grade/Form:** Click or tap here to enter text.
3. **Does your child ever refuse to go to school?**

Never  Sometimes (1 or less times per week)  Often (2+ times per week)

1. **Does your child have any behavioural issues at school? Eg. Hitting, tantrums, aggression, defiance, not listening to instructions. If yes, describe:**

Click or tap here to enter text.

1. **Does your child have any academic/learning issues? E.g., reading accuracy/comprehension, spelling, grammar, completing homework/assessments. If yes, describe:**

Click or tap here to enter text.

**(Proceed to next page)**

**GOALS OF THERAPY**

**Please mark all areas which you would like to see improved or supported:**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Depression |  |  |
| Anxiety |  |  |
| Anger |  |  |
| Stress |  |  |
| Irritability |  |  |
| Attention |  |  |
| Distractibility |  |  |
| Planning |  |  |
| Organization |  |  |
| Language Skills |  |  |
| Motor Skills |  |  |
| Reading |  |  |
| Writing |  |  |
| Studying/Learning |  |  |
| Behaviour with family |  |  |
| Behaviour at school |  |  |
| Socializing |  |  |

*NB: Please note that all our psychologists are trained in numerous types of therapy and tend to combine therapies and personalize the approach according to the specific needs of patients. If you have any specific requests on types of therapy, we can discuss them with you.*

**LIMITS TO CONFIDENTIALITY**

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows:

**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Minors/Guardianship** Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

***I agree to the above limits of confidentiality and understand their meanings and ramifications.***

\*

**Client Signature (Client’s Parent/Guardian if under 18)**

Click or tap here to enter text.

**Counsellor’s Signature**

Click or tap here to enter text.

**Today’s Date**