

CHILD INTAKE FORM
(Please complete in Ink)

CHILD

1. Child's Name _____ Sex _____ Age _____ DOB _____

2. Natural Child Yes / No If adopted, at what age _____ Foster since _____

3. Parent's Names (include step-parents, foster parents, inc.)

4. Comments about custody and visitation (if applicable):

5. Primary reason you are concerned about your child?

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

- | | |
|--------------------------------------|--------------------------------------|
| a. _____ Sleep problems | _____ Morbid thoughts |
| _____ Lack of interest in activities | _____ Suicidal thoughts or threats |
| _____ Unassertive | _____ Suicidal plans / attempts |
| _____ Fatigue/low energy | _____ Mood swings |
| _____ Concentration problems | _____ Depression |
| _____ Appetite/weight changes | _____ Changed level of activity |
| _____ Withdrawal | _____ Cries easily |
| b. _____ Forgetful/memory problems | _____ Talks excessively / interrupts |
| _____ Short attention span | _____ Easily distracted |
| _____ Aggressive behavior | _____ Irritable |
| _____ Can't sit still | _____ Impulsive |
| _____ Not interested in peers | _____ Difficulty following rules |
| _____ Picked on / bullied by peers | _____ Problem completing schoolwork |

- c. Excessive worry / fearfulness
 Anxiety or panic attacks
 Social fears, shyness
 Separation problems
 Bedwetting / soiling
 Headaches, stomachaches
 Odd beliefs / fantasizing

- Nightmares
 Frequent tantrums
 Resistive to change
 School refusal
 Perfectionism
 Odd hand / motor movements
 Hallucinations

- d. Lying
 Trouble with the law
 Running away
 Truancy, skipping school
 Hurting others sexually
 Alcohol / drug use
 Argumentative / defiant
 Swears
 Blames others for mistakes

- Stealing
 Being destructive
 Fire setting
 Hurting others / fighting
 Acts as if has no fear
 Short tempered
 Easily annoyed / annoys others
 Discipline problem
 Angry and resentful

Brothers and Sisters

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

SCHOOL HISTORY

- Present School: _____ Grade: ____ Teacher: _____
- Has child ever repeated any grade? _____
- Is child in special education services? No ____ Yes, what kind? _____
- Please describe academic or other problems your child has had in school

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. **Pregnancy**

Mother used during pregnancy: alcohol ____ drugs ____ cigarettes ____

Delivery: Normal ____ Breech ____ Cesarean ____ Transectional ____
 Full-term ____ Premature ____ if premature, number of weeks ____

Birth Weight: _____

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)

2. Developmental History

- State approximate age when child did the following:
Walked alone _____ Said first word _____ Used 2-word phrases _____
- Understood and followed simple directions _____
- Reasonably well toilet trained _____
- Did child cry excessively? _____ Rarely cried _____

3. Health History of Child

In the first two years, did your child experience: ___Separation from mother,
___Out of home care, ___Disruption in bonding, ___Depression of mother, ___Abuse,
___Neglect, ___Chronic pain, ___Chronic Illness, ___Parental Stress

- Child's Doctor: _____
 - Date of last physical exam: _____
 - Vision problems? Yes _____ No _____ Hearing problems? Yes _____ No _____
 - Dental problems? Yes _____ No _____
 - Any head injuries or loss of consciousness? Yes _____ No _____
 - Child's history of serious illness, injury, handicaps, or hospitalization?
No _____ Yes – describe and give dates _____
 - Is your child currently taking any medications? No _____ Yes _____ name medications _____
-

- List any medicines previously used for emotional problems: were they helpful? _____

- Allergies to drugs or medicines? No ____ Yes ____ (list) _____
- Allergies to any foods? No ____ Yes ____ (list) _____

- Are there any foods that you limit or do not give this child? No ____ Yes ____
(list) _____.
- Allergies to environmental conditions? No ____ Yes ____ (list) _____
- Does anyone in the household smoke? No ____ Yes ____
- About how many hours does this child watch TV, videos, etc per day _____
- Are you afraid someone you know may injure/harm this child? No ____ Yes ____

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- Does this child have a Health Care Directive? No ____ Yes ____
If yes, please list where (clinic) it is on file _____
- Any previous psychological or psychiatric treatment? No ____ Yes ____
Whom/where _____ when _____
- Any previous testing (school/psychological)? No ____ Yes ____
Whom/where _____ when _____
- Do you think your child's use of chemicals is a problem? No ____ Yes ____
Type: Alcohol ____ Marijuana ____ Other drugs _____
Comments: _____

Family History:

Chemical use (now & past): No ____ Yes ____ Which parent _____
Type: Alcohol ____ Marijuana ____ Other drugs _____

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

Has child witnessed domestic violence? __Y, __N, Specify: _____

How is your child disciplined? Please list each method and frequency of use: _____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? __Y, __N, __Suspected. Specify: _____

2. Has your child been physically abused? __Y, __N, __Suspected. Specify: _____

3. Has your child been sexually abused? __Y, __N, __Suspected. Specify: _____

4. Other stressors or traumas? _____

What are your child's strengths?

Any additional comments or information that would be helpful to us?

Signature of person completing form / relationship to client:

Name _____ Relationship _____ Date: _____
