Tree of Life Counseling Services
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# Child Therapy Intake Form

Child's name: _____
DOB: _____ Age: _____ Sex: _____
Home address: _____

Name of person completing this form: _____
Relationship to the child: _____
Custody status: _____
Phone: _____ Email: _____

Name of other parent/legal guardian: _____
Relationship to the child: _____
Phone: _____ Email: _____

Brothers and sisters:

| Full name | Age | Sex | Relationship to child (full, step, half, adopted) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Child's Developmental and Medical History

Did the mother use drugs, alcohol, or tobacco during the pregnancy? Yes ☐ No ☐

Delivery: Vaginal ☐ Breech ☐ Cesarean ☐ Other ☐
Full term _____ Premature, if so how many weeks? _____

Birth weight: _____ Birth Height: _____

Problems at birth (i.e.: infant placed in the NICU)?

_____
_____
_____
_____

Did your child walk, talk, and toilet train on time? If no, explain.
Yes ☐ No ☐

_____
_____
_____

Has your child been diagnosed with any illness? If yes, explain.
Yes ☐ No ☐

_____
_____
_____

Does your child have any allergies? If yes, explain. Yes ☐ No ☐

_____
_____
_____

Is your child currently taking any medications? If yes, explain. Yes ☐ No ☐

_____
_____
_____

What is the name of your child's medical doctor: _____

Address: _____ Phone number: _____

Date of your child's last physical? _____

**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**

Name of child's school: _____

Teacher: _____ Counselor: _____

Grade: _____

Has your child ever repeated a grade? If yes, explain. Yes ☐ No ☐

_____

_____

_____

Typical grades: _____

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**

What is the reason for your child's visit?

_____

_____

_____

_____

_____

_____

When did this start?

_____

_____

_____

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

_____

_____

_____

What are your goals for your child's treatment?

_____

_____

_____

How long do you expect your child to be in therapy?

Less than 3 months ☐ 3-6 months ☐

6-9 months ☐ 9 or more months ☐

What are your child's positive qualities and strengths?

_____

_____

_____

Is there anything else you would like to mention?

_____

_____

_____

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