Tree of Life Counseling Services
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(248) 608-4514

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.