SERENITY HILL
HEALTH CARE

CHILD INTAKE FORM

(Please complete in Ink)

CHILD

1. Child's Name: _____ Sex_____ Age_____ DOB_____

2. Natural Child? Yes / No If No, Adopted (at what age) _____ or Foster since _____

3. Parent's Names (include stepparents, foster parents):

_____

_____

4. Parent Contact Info: Ph: _____ Email: _____

5. Mailing Address: _____

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

_____

_____

7. Primary reason you are concerned about your child?

_____

_____

SIBLINGS

First Name	Last Name	Sex	Age	Relationship to Child (full, step, half or foster sibling)

SCHOOL HISTORY

1. Present School: _____Grade: ____ Teacher: _____

2. Has child ever repeated any grade? _____

3. Is child in special education services? No ____ Yes, what kind? _____

4. 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 (Please check all that apply):

___Separation from mother ___Out of home care ___Disruption in bonding

___Depression of mother ___Abuse ___Neglect ___Chronic pain

___Chronic Illness ___Parental Stress

- Name of 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(s) of medication
  _____

- List any medicines previously used for emotional problems: Were they helpful? _____
  _____
- Allergies to drugs or medicines? No ____ Yes ____ (Please list) _____

3. Health History of Child - **Continued**

- Allergies to any foods? No ____ Yes ____ (Please list)_____
- Are there any foods that you limit or do not give this child? No ____ Yes ____
  (Please list) _____
- Allergies to environmental conditions? No ____ Yes ____
  (Please 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 ____
  (National Domestic Violence Hotline 1-800-799-7233)
- 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: _____

  _____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? No ___Yes ___ Suspected ___Specify: _____

_____

2. Has your child been physically abused? No ___Yes ___ Suspected ___Specify:_____

_____

3. Has your child been sexually abused? No ___Yes ___ Suspected ___Specify: _____

_____

4. Other stressors or traumas? _____

_____

What are your child's strengths? _____

_____

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

_____

SYMPTOM/PROBLEM CHECKLIST

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

__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
__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
__Excessive worry/fearfulness
__Nightmares
__Anxiety or panic attacks
__Frequent tantrums
__Social fears/shyness
__Resistive to change
__Separation problems
__School refusal
__Bedwetting/soiling
__Perfectionism
__Headaches/stomachaches
__Odd hand/motor movements
__Odd beliefs/fantasizing hallucinations
__Lying
__Stealing
__Trouble with the law
__Being destructive
__Running away
__Fire setting
__Truancy/skipping school
__Hurting others/fighting
__Hurting others sexually
__Acts as if has no fear
__Alcohol/drug use
__Short tempered
__Argumentative/defiant
__Easily annoyed/annoys others
__Swears
__Discipline problem
__Blames others for mistakes
__Angry and resentful

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? __No __ Yes Specify: _____

_____

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

_____

Printed name of person completing form: _____

Relationship to the child: _____

Signature: _____ **Date:** _____

For Office Use Only

Name of Person Receiving Forms: _____

Signature: _____ Date: _____