



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) _____
- 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: _____

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: _____

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? _____

Printed name of person completing form: _____

Relationship to the child: _____

Signature: _____ **Date:** _____

For Office Use Only

Name of Person Receiving Forms: _____

Signature: _____ Date: _____

SYMPTOM/PROBLEM CHECKLIST

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

- | | |
|--|---|
| ☐ Sleep problems | ☐ Frequent tantrums |
| ☐ Morbid thoughts | ☐ Social fears/shyness |
| ☐ Lack of interest in activities | ☐ Resistive to change |
| ☐ Suicidal thoughts or threats | ☐ Separation problems |
| ☐ Unassertive Suicidal plans/attempts | ☐ School refusal |
| ☐ Fatigue/low energy | ☐ Bedwetting/soiling |
| ☐ Mood swings | ☐ Perfectionism |
| ☐ Concentration problems | ☐ Headaches/stomachaches |
| ☐ Depression | ☐ Odd hand/motor movements |
| ☐ Appetite/weight changes | ☐ Odd beliefs/fantasizing hallucinations |
| ☐ Changed level of activity | ☐ Lying |
| ☐ Withdrawal | ☐ Stealing |
| ☐ Cries easily | ☐ Trouble with the law |
| ☐ Forgetful/memory problems | ☐ Being destructive |
| ☐ Talks excessively/interrupts | ☐ Running away |
| ☐ Short attention span | ☐ Fire setting |
| ☐ Easily distracted | ☐ Truancy/skipping school |
| ☐ Aggressive behavior | ☐ Hurting others/fighting |
| ☐ Irritable | ☐ Hurting others sexually |
| ☐ Can't sit still | ☐ Acts as if has no fear |
| ☐ Impulsive | ☐ Alcohol/drug use |
| ☐ Not interested in peers | ☐ Short tempered |
| ☐ Difficulty following rules | ☐ Argumentative/defiant |
| ☐ Picked on/bullied by peers | ☐ Easily annoyed/annoys others |
| ☐ Problem completing schoolwork | ☐ Swears |
| ☐ Excessive worry/fearfulness | ☐ Discipline problem |
| ☐ Nightmares | ☐ Blames others for mistakes |
| ☐ Anxiety or panic attacks | ☐ Angry and resentful |