

Positive Change Counseling Services

A Professional Corporation of Marriage and Family Therapists

406 Main Street

Vacaville, CA 95688

(707) 446-8600

Minor Intake Paperwork

Today's Date _____

Referred By _____

Please take time to fill out this form. This will aid greatly in providing appropriate therapeutic care for your child.

Name of Child _____ Date of Birth _____

- Name of parent _____ Date of Birth _____

Address _____ City _____ Zip _____

Phone _____ Email _____

- Name of parent _____ Date of Birth _____

Address _____ City _____ Zip _____

Phone _____ Email _____

Are there any custody issues? __Yes __No

If so, what are the legal stipulations? _____

Current school _____ City _____

Emergency Contact _____ Phone _____

Relationship to Client _____ Address _____

Current Living Situation

Please circle which of the following best describes your child's living situation.

- | | |
|----------------|-----------------------|
| Rent apartment | Shelter |
| Rent house | Homeless |
| Own house | Group home |
| Foster care | Residential treatment |

Support System

List the household members living in your child's home.

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

List important friends, family members or relatives living outside of your child's home.

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Name _____ Age _____ Relationship to you _____

Areas of Concern

What issues/concerns cause you to seek treatment for your child? Please describe.

When did the problems start? _____

What would you like your child to achieve in therapy?

Do you have any concerns or fears about therapy? __Yes __No

If yes, please describe

Psychological History

Name of previous therapist _____ Phone _____

Dates of treatment _____ Focus of treatment _____

What was helpful/not helpful about treatment? _____

Has your child had psychological testing? _____ If yes, by whom? _____

Has your child ever had suicidal or homicidal

- Thoughts? _____
- Attempts? _____

Has your child been hospitalized for mental or emotional problems? __Yes __No If so,

- When? _____
- How long? _____
- What was the reason? _____

Hospital Name _____

Current Medications

1. Name of medication _____ Dose _____
Start Date _____ Prescribed by _____ Phone _____
2. Name of medication _____ Dose _____
Start Date _____ Prescribed by _____ Phone _____
3. Name of medication _____ Dose _____
Start Date _____ Prescribed by _____ Phone _____
4. Name of medication _____ Dose _____
Start Date _____ Prescribed by _____ Phone _____

Medical History

Has your child ever been diagnosed with a serious illness?

Please describe _____

Date of last physical exam _____ Physician _____ Phone _____

Is your child experiencing any medical/physical symptoms you attribute to emotional, or stress-related condition? Please describe _____

Are you concerned your child is using alcohol or drugs? Yes No

If yes,

- What makes you think so? _____
- What has been done to reduce risk? _____
- Has law enforcement been involved? _____

Family of Origin History

Description of your child's relationship with Mother.

Description of your child's relationship with Father.

Please describe your child's experience

- At home

- At school

Has your child ever subjected to abuse? Yes No

If yes, please describe verbal, bullying, physical, and/or emotional abuse.

Has your child ever been a victim of a violent crime? Please describe.

Early Development

Were there birthing complications? Yes No

If yes, please describe _____

Was the baby unwanted by either parent? Yes No

Please check any issue that applied to your child in the early years.

Bed wetting

Head banging

Rocking

Sleeping problems

Grind teeth

Avoid eye contact

Feeding problems

Flapping hands/twirling fingers

Using "I" properly

Focus on spinning objects

Seeming in own world

Tantrums

Over cautious

Fearful

Avoid new situations

Accident prone

Lack of ability to focus

Poor coordination

Avoid new people

Depressed mood

Nail biting

Check any task your child did NOT accomplish at normal age.

- | | | |
|--|--|--|
| <input type="checkbox"/> Crawl | <input type="checkbox"/> Dress self | <input type="checkbox"/> Tie shoes |
| <input type="checkbox"/> Walk | <input type="checkbox"/> Ride a bike | <input type="checkbox"/> First word |
| <input type="checkbox"/> Feed self | <input type="checkbox"/> Three word sentence | <input type="checkbox"/> Toilet training |
| <input type="checkbox"/> Write legibly | <input type="checkbox"/> Manipulate small toys | <input type="checkbox"/> Puzzles |

How was your child disciplined by each parent? _____

Were there times discipline got out of control? Yes No

Academics

Age of child when entered school _____

How did your child react to separating from caregivers to go to school? _____

Grades

- In elementary school _____
- In middle school _____
- In high school _____

Identified problems

Has your child been in trouble at school? Yes No

If yes,

- Please describe

- When did they begin? _____
- What has been done to help? _____

Does your child have an IEP in place? Yes No

Other Information

Spiritual identity/Orientation _____

Interests/Hobbies _____

Has Child Protective Services ever been involved? Yes No

Is your child involved with legal problems? Yes No If yes, for what? _____

Areas of Concern

Please check any areas you are concerned about. Check all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Strange behaviors | <input type="checkbox"/> Lack of friends |
| <input type="checkbox"/> Crying a lot | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Avoid others |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Destroy things | <input type="checkbox"/> Lack of attention |
| <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Promiscuity | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Self injurious behaviors |
| <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Suicidal thoughts/plans | <input type="checkbox"/> Vandalism |
| <input type="checkbox"/> Hot temper | <input type="checkbox"/> Odd beliefs | <input type="checkbox"/> Fire setting |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Substance use | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Physical problems |
| <input type="checkbox"/> Worry excessively | <input type="checkbox"/> Perfectionist | <input type="checkbox"/> Weight loss |

Strengths

Please check any areas you consider your child's strengths. Check all that apply.

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Employed | <input type="checkbox"/> Easy going | <input type="checkbox"/> Athletic |
| <input type="checkbox"/> Independent | <input type="checkbox"/> Regularly copes well | <input type="checkbox"/> Structures time well |
| <input type="checkbox"/> Intelligent | <input type="checkbox"/> Caring | <input type="checkbox"/> Loyal |
| <input type="checkbox"/> Responsible | <input type="checkbox"/> Honest | <input type="checkbox"/> Positive outlook |
| <input type="checkbox"/> Spiritual | <input type="checkbox"/> Helpful | <input type="checkbox"/> Artistic |
| <input type="checkbox"/> Playful | <input type="checkbox"/> Good looking | <input type="checkbox"/> A leader |

Thank you for taking the time to fill out this intake form.

Printed Name

Signature

Date