April Blair, M.A.

CHILD THERAPY INTAKE FORM

Please complete on behalf of your child

Name of person completing this form: _____ Your relation to the child: _____ Phone: _____ Email: _____

Name of other parent/legal guardian: _____ Phone: _____ Email: _____

Child's first name: _____ Last name: _____ Age: _____ Birth day: _____ Month: _____ Year: _____ Ethnicity: _____ Religion: _____ Sex/gender: _____ Home address: _____ Who does your child live with? _____

ACADEMIC INFORMATION:

Name of child's school: _____ Grade/year: _____ Program: _____ Typical grades: _____

THE REASONS FOR YOUR CHILD'S VISIT:

_____
_____
_____
_____
_____

How intense is your child's emotional distress?

(Mild)1 2 3 4 56 7 8 9 10(Severe)
Please describe: _____
_____

Overall, how much do the problems affect your child's ability to perform school, get along with others, and perform daily tasks such as chores?
(Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)
Please describe: _____
_____

When did these problems start? What was going on in your child's life at that time?

_____
_____
_____
_____
_____

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PSYCHIATRIC AND MEDICAL HISTORY

Please list any psychiatric or "mental" problems your child has been diagnosed with:
_____
_____
_____

Please list any medical or "physical" problems that your child has been diagnosed with:
_____
_____
_____

Please list any medications your child currently takes, and what they are taken for:
_____
_____
_____

Name of Family doctor: _____ Phone: _____ Last check-up was during the month of: _____ Year: _____
Results: _____
_____

Name of Psychiatrist: _____ Phone: _____ Last visit was during the month of: _____ Year: _____
Results: _____
_____

MENTAL HEALTH TREATMENT HISTORY

Has your child ever been hospitalized for psychological or psychiatric reasons? ☐No ☐Yes
If yes, please describe when and where, and for which reasons.
_____
_____
_____

Any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment). _____
_____
_____

CURRENT HABITS
Please describe your child's current habits in each of the following areas:

Smoking: Drinking:
Drug use:
TV use:
Internet use: Video game use: Caffeine intake: Exercise:

Eating:
Sleeping:

Fun and relaxation:
Chores and responsibilities:

RELATIONSHIPS

Please describe your child's relationships with each of the following people, if applicable:

Biological Mother: Biological Father: Step-parents: Legal guardians: Siblings:

Extended family:
Your children:
Friends:
Romantic partner(s):
Colleagues or classmates:
Total number of close, supportive relationships:

STRESSFUL LIFE EVENTS

Please describe any significant or stressful life events that your child has been experiencing:

Yes/No If yes, please describe

A recent move or change in school?

Abuse or neglect?

Bullied or ignored by peers?

Academic difficulties?

Weight control issues?

Sexual orientation concerns?

Self-injury?

Death or Illness of a loved one or pet?

Family conflict?

Separation or Divorce?

Other?

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What are your child's positive qualities and skills? What do you like about your child? What qualities have helped your child to succeed at overcoming difficulties in the past?

Please tell us about your child's interests (sports, hobbies, talents, etc.)

Does your child agree that the problem that she or he is seeking help for is problematic?

What are some goals for your child's therapy? What would you like them to achieve by attending therapy?

What concerns do you have about your child attending therapy or working on these problems?

Is there anything else that you would like to mention?