CROSSVILLE COUNSELING CENTER
Child Intake Form

Please print clearly. Please fill out form completely. Readmit: ___ Yes ___No
Date: _____ **Client's Social Security #:**_____ **Case #:** _____
Client's *Legal* Last Name: _____ ***Legal*** **First Name:** _____ **M.I.** ____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Tel. (home) _____ (work)_____ (cell) _____
OK to leave messages? Home: ___Yes ____No **Work:** ___Yes ___No **Cell:** ___Yes ___No
Email Address: _____ **Can Emails be sent: __Y __N**
Birthdate: ____/____/_____ **Age:**____ **Gender:** __F __M **Race:** _____
Name of Parent/Guardian: _____ **Phone:** _____
Address: _____ **City:**_____ **State:** _____ **Zip:** _____
Form Completed By: _____ **(Please submit address below, if different from above)**
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Emergency Information:
In case of emergency, contact:
Name (1) _____ Relationship _____ Phone _____
Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____
Address _____ City _____ State _____ Zip _____

Primary Care Physician _____ Phone _____
Address _____ City _____ State _____ Zip _____
Can your PCP be contacted for continuity of care, if needed: _____Yes _____Refused

Employment Information (If client is a child too young to work, use parents employment)
Client/Guardian: Place _____ Occupation _____ Hrs. ____
Parent: Place _____ Occupation _____ Hrs. ____

Insurance Information

Primary Insurance _____
Contract/ID# _____
Group/Acct# _____
Subscriber _____
Subscriber Social Security # _____
Subscriber Date of Birth _____
Client's relationship to Subscriber
___Self ___Son/Daughter ____Other

Secondary Insurance _____
Contract/ID# _____
Group/Acct# _____
Subscriber _____
Subscriber Social Security # _____
Subscriber Date of Birth _____
Client's relationship to Subscriber
___ Self ____Son/Daughter ___Other

Referral Source
How did you hear of Crossville Counseling? _____
Address _____ City_____ State _____ Zip _____
Phone _____

Primary reason(s) for seeking services:

___Anger management	___Anxiety	___Coping	___Depression
___Eating Disorder	___Fear/phobias	___Mental confusion	___Sexual concerns
___Sleeping problems	___Addictive behavior	___Alcohol/drugs	___Past Trauma
___Self-injury	___Self-esteem	___Behavioral	___Hyperactivity

___Other mental health or behavioral concerns (specify) _____
How long have these symptoms been present?_____

Any Additional information that would assist in understanding your concerns or problems? _____
_____

How much family involvement would you like to see in therapeutic process? _____
_____

Describe how the above symptoms impair your ability to function effectively (e.g., socially, occupationally, academically, emotionally, physically) _____
_____

Stressors (Check all that apply)

___Arrest ___Court trial ___Crime (witness/victim) ___ Upcoming surgery
___Conflict w/teacher ___Conflict w/parent ___Conflict w/sibling ___Breakup of relationship
___Birth of a sibling ___Change in residence ___Change of school ___Death of a sibling
___Death of a friend ___Death of parent ___Death of spouse ___Death of grandparent
___Divorce of parents ___Family conflict ___Illness (child/parent) ___ Family financial status
___Parental Discord ___Personal Injury ___Abuse (physical, sexual, verbal)

Counseling/Prior Treatment History (Information about client past and present)

	Yes	No	When	Where	Overall experience
Mental Health Counseling	___	___	_____	_____	_____
			_____	_____	_____
Suicidal thoughts/attempts	___	___	_____		
Drug/Alcohol treatment	___	___	_____	_____	_____
M.H. Hospitalizations	___	___	_____	_____	_____
Involvement w/self-help Groups (AA, al-alnon, etc.)	___	___	_____	_____	_____

Any immediate family in treatment currently? If yes, whom and where? _____
Previous mental health diagnosis(es): _____
Permission to contact Prior Mental Health professionals/hospitals? ___Yes ___No ___N/A

What areas of your life are being affected by the above?

Social

___Unable to form or maintain friendships ___Withdrawal from family and friends (excessive desire to be alone)
___Increased conflict with others ___Verbally aggressive ___Loss of interest in activities
___Phobias ___Argues with family/friends ___Lack of assertiveness
___Conflict with authority ___Excessive dependency ___Poor judgment
___Lack of communication ___Physical aggression ___Social isolation

Occupational (if client works)

___Unable to maintain job ___Absenteeism ___Conflicts with co-workers
___Tardiness ___Reduced productivity ___Disciplinary action for poor performance

Physical

___Decreased energy/fatigue ___Difficulty getting out of bed or insomnia ___Decreased/Increased appetite
___Substantial weight loss or gain ___Frequent illness ___Physical complaints (headaches, stomachaches, etc.)

Academic

___Failing grades ___Detention ___Reduced productivity at school
___Tardiness ___Suspensions ___Fighting/conflicts with student/teachers
___Overachievement ___Underachievement ___Refusal to go to school
___Daydreaming in class ___Truancy ___Difficulty remembering assignments
___Disruptive in class ___Excessively shy ___Incomplete assignments/Careless mistakes
___Honors classes ___Organized ___Special Ed. (LD or ADHD or MR or Visual/Audio Impaired)
___Self-directed ___Responsible ___Cooperative

Case #_____

Behavioral/Emotional

___Affectionate	___Crying spells	___Irritability/mood swings	___Anger/rage
___Anxiety	___Blinking/Jerking	___Verbally Aggressive	___Disorganized thoughts
___Memory problems	___Bizarre behavior	___Physically Aggressive	___Bedwetting
___Attachment to dolls	___Avoids adults	___Bullies, threatens	___Concentration problems
___Worries excessively	___Careless, reckless	___Chest pains	___Clumsy
___Confident	___Cooperative	___Computer addiction	___Emotional breakdowns
___Defiant	___Depression	___Destructive	___Emotionally overwhelmed
___Difficulty speaking	___Dizziness	___Eating disorder	___Enthusiastic
___Expects failure	___Fatigue	___Excessive masturbation	___Fearful
___Frequent injuries	___Frustrated easily	___Gambling	___Generous
___Hallucinations	___Head banging	___Heart problems	___Hopelessness
___Hurts animals	___Imaginary friends	___Impulsive	___Lazy
___Learning problems	___Lies frequently	___Listens to reason	___Loner
___Low self-esteem	___Messy	___Moody	___Nightmares
___Obedient	___Often sick	___Oppositional	___Over active
___Overweight	___Panic attacks	___Phobias	___Poor appetite
___Psychiatric problems	___Quarrels	___Sad	___Selfish
___Separation anxiety	___Sets fires	___Sexual addiction	___Sexual acting out
___Shares	___Sick often	___Short attention span	___Shy, timid
___Sleeping problems	___Slow moving	___Soiling	___Speech problems
___Steals	___Stomachaches	___Suicidal threats	___Suicidal attempts
___Talks back	___Teeth grinding	___Thumb sucking	___Tics or twitching
___Unsafe behaviors	___Weight loss	___Withdrawn	___Other

Please describe any of the above (or other) concerns: _____
_____
_____

Education

Current School _____ School Phone Number _____
Type of school ___Public ___Private ___Home Schooled Grade _____ (if summer grade just completed)
Has client ever been held back? ___Yes ___No Describe: _____
Which subjects does client enjoy in school? _____
Which subjects does client dislike in school? _____
What are client's typical grades in school? _____
Have there been any recent changes in grades? _____
Has child been tested psychologically? ___Yes ___No Where/When: _____
_____

Parental Information

With whom does the child live at this time?_____
Parent's current relationship status:
___Single ___Divorce in process ___Unmarried, living together ___Legally married
___Separated ___Divorced ___Widowed ___Engaged ___Never married
Give date of any type of separation:_____ Client's age at time of separation: _____
Who has legal custody of client: _____
Is there any significant information about the parents' relationship or treatment toward the child that might be beneficial in counseling? ___Yes ___No If Yes, describe _____
_____

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Client's Mother

Name _____ Age____ Occupation_____ ___FT ___PT
Where employed _____ Work telephone_____
Mother's Highest level of education _____ Mother remarried # of times:_____
Is there anything notable, unusual or stressful about the child's relationship with the mother? _____
_____
How is the child disciplined by the mother (e.g. grounding, spanking)? _____
For what reason is the child disciplined by the mother? _____

Client's Father

Name _____ Age____ Occupation_____ ___FT ___PT
Where employed _____ Work telephone_____
Father's Highest level of education _____ Father remarried # of times:_____
Is there anything notable, unusual or stressful about the child's relationship with the father? _____
_____
How is the child disciplined by the father (e.g. grounding, spanking)? _____
For what reason is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Name of Siblings	**Age**	**Gender (M/F)**	**Lives**	**Quality of relationship with client**
_____	___	_____	__Home __Away	___poor ___average ___good
_____	___	_____	__Home __Away	___poor ___average ___good
_____	___	_____	__Home __Away	___poor ___average ___good
_____	___	_____	__Home __Away	___poor ___average ___good
Others in the home	**Age**	**Gender (M/F)**	**Relationship**	**Quality of relationship with client**
_____	___	_____	_____	___poor ___average ___good
_____	___	_____	_____	___poor ___average ___good
_____	___	_____	_____	___poor ___average ___good

Special circumstances (e.g., raised by person other than parent) _____
_____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? ___Yes ___No
Was the pregnancy with client planned? ___Yes ___No Length of pregnancy_____
Mother's age at client's birth: ____ For Mother - Child # ___ of ___total children
Father's age at client's birth: ____ For Father - Child # ___ of ___total children
While pregnant did the mother smoke? ___Yes ___No If Yes, what amount _____
Did the mother use drugs or alcohol? ___Yes ___No If Yes, what type/amount _____
While pregnant, did the mother have any medical/emotional difficulties? (e.g. surgery, hypertension, medication) ___Yes ___No If Yes, describe: _____
Length of labor _____ Induced ___Yes ___No Caesarean? ___Yes ___No
Baby's birth weight: _____ Baby's birth length:_____
Describe any physical/emotional complications with the delivery: _____
Describe any complications for the mother or baby after birth: _____
Length of hospitalization Mother _____ Baby _____

Infancy/Toddlerhood (check all that apply)

___Breast fed	___Milk allergies	___Vomiting	___Diarrhea
___Bottle fed	___Rashes	___Colic	___Constipation
___Not cuddly	___Cried often	___Rarely cried	___Overachieve
___Resisted solid food	___Trouble sleeping	___Lethargic	___Irritable when awakened

Case #_____

Developmental History (Please note the age at which the following behaviors took place)

Sat alone _____ Dressed self _____
Took 1st steps _____ Tied shoe laces _____
Spoke words _____ Rode two-wheeled bike _____
Weaned _____ Dry during day _____
Fed self _____ Dry during night _____
Attended Infant Day Care: ___Yes ___No Attended Preschool ___Yes ___No
Attended Kindergarten (age) _____ Attended 1st grade (age) _____
Compared with others in family, client's development was ___Slow ___Average ___Fast

Age for following developments (fill in where applicable)

Began puberty _____ Menstruation _____
Voice change _____ Breast development _____
Issues that affected child's development (e.g. inadequate nutrition, neglect, several moves, foster care)
_____
_____
Any history of being abused by others? ___No ___Yes If Yes, what type(s) of abuse?
___Emotional ___Sexual ___Physical ___Verbal ___Other, describe _____
Client's age when abuse occurred: _____

Most recent examinations

Type of examination	***Date of most recent visit***	***Results***
Physical	_____	_____
Dental	_____	_____
Vision	_____	_____
Hearing	_____	_____

Immunization record (Please add date that vaccinations occurred)

	2-3 Months	4-5 Months	6-11 Months	12-15 Months	12-18 Months	4-6 Years
DTP/Dta/DT						
Polio						
Hib						
MMR						
Varicella						

Child's Peer Relationships

___Spontaneous ___Follower ___Leader ____Difficulty making friends
___Makes friends easily ___Long-time friends ___Shares easily ____Other: _____

Social Skills: ___Good ___Average ___Poor

Who handles responsibility for your child in the following areas?

School ___Mother ___Father ___Shared ___Other (specify) _____
Health ___Mother ___Father ___Shared ___Other (specify) _____
Problem Behavior ___Mother ___Father ___Shared ___Other (specify) _____
Discipline Techniques: _____

Cultural/Ethnic

To which cultural or ethnic group do you belong? _____
Are you experiencing any problems due to cultural or ethnic issues? ___Yes ___No
If Yes, describe_____
Other cultural/ethnic information_____

Case #_____

Spiritual/Religious

How important to you are spiritual matters to you? ___Not at all ___Little ___Moderate ___Much
Are you affiliated with a spiritual or religious group? ___Yes ___No
If Yes, describe _____
Were you raised within a spiritual or religious group? ___Yes ___No
If Yes, describe _____
Would you like your spiritual/religious beliefs incorporated into the counseling? ___Yes ___No
If Yes, describe _____

Client's Current Legal Status **Is your child mandated for treatment? ___Yes ___No**

If Yes, explain: _____
Are you involved in any active cases (traffic, civil, criminal)? ___Yes ___No
If Yes, please describe and indicate the court and hearing/trial dates and changes_____
_____
Are you presently on probation or parole? ___Yes ___No
If Yes, please describe_____
Do you have a DCS Worker? ___Yes ___No Why? _____
DCS Name: _____ Phone:_____

Client's Past Legal History

Traffic violations ___Yes ___No DWI, DUI, etc. ___Yes ___No
Criminal involvement ___Yes ___No Civil involvement ___Yes ___No
If you responded Yes to any of the above, please fill in the following information.

Charges	**Date**	**Where (city)**	**Results**
_____	_____	_____	_____
_____	_____	_____	_____

Leisure/Recreational/Interests/Social

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, social organizations, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nutrition

Meal	How often	Typical foods eaten	Typical amount eaten
Breakfast	____/week	_____	_____
Lunch	____/week	_____	_____
Dinner	____/week	_____	_____
Snacks	____/week	_____	_____

Additional comments on nutrition: _____
_____

Medical/Physical Health Condition (Check any problem areas client/family has or has had)
C=Client **MO**=Mother **FA**=Father **S**=Sibling **GM**=Grandmother **GF**=Grandfather **O**=Other blood relative

Condition	Currently	In Past	Never	Condition	Currently	In past	Never
Abortion				Loss of consciousness			
Anemia				Memory loss			
Appetite change				Numbness			
Arthritis				Pain (daily, longer than 2 weeks)			
Asthma				Palpitations			
Back pain				Paralysis			
Blood in stool				Rheumatic fever			
Blurred vision				Seizures			
Caffeine use				Shortness of breath			
Chest pain				Skin disease			
Chicken pox				Sleep apnea			
Chronic cough				Sleep difficulties			
Colitis or irritable bowel				Stroke or TIA			
Confusion or disorientation				Swallowing difficulty			
Constipation				Dental problems			
Diabetes				Thyroid disease			
Diarrhea				Tuberculosis			
Dizziness				Ulcers or indigestion			
Emphysema				Urination difficulty			
Fainting				Sexually transmitted disease			
Glaucoma				Weakness			
Head injury				Recent Weight gain			
Headaches (frequent)				Recent Weight loss			
Hearing loss				Malnutrition			
Heart disease				Epilepsy			
Miscarriage				HIV/AIDS			
Infertility				Hepatitis			
Scoliosis				Energy level change			
Multiple sclerosis				Other			

Case #_____

Do any of these illnesses significantly challenge or limit client's ability to function at school or at home?
If yes, please provide details:

_____

List any current health concerns: _____

List any recent health or physical changes:_____

Does client have any physical/psychological disabilities? ___Yes ___No

Please list all of client's current prescription and non-prescription (over-the-counter) medications:

Name of your current medicine	What do you use it for?	When did you begin taking it?	What is the strength of each tablet or capsule	What dose do you take, and how often?	When was the most recent dosage change?	Prescribing Doctor

Please list all medication that client has taken <u>in the past</u>.

Name of your previous medicine	What did you use it for?	How long did you take it?	When did you stop taking it?	Why was it stopped?	Did the medicine cause any problems?	Prescribing Doctor

Will you sign for permission to contact your prescribing doctor, if not your PCP? ___ Yes __ No ___N/A

Describe client's overall compliance with the above medications _____

_____

Please list all nutritional and herbal supplements that client currently takes: _____

_____

Medication Allergies _____

Have you ever had any bad reactions (made you feel worse) to prior medications (if so, specify):

_____

Do you (client) feel suicidal at this time? ___Yes ___No

If Yes, explain _____

_____

Do you (client) feel homicidal at this time? ___Yes ___No

If Yes, explain _____

_____

Have you ever felt homicidal/suicidal? ___Yes ___No When?_____

Case #_____

Was treatment sought? _____

Are you currently involved in any risk taking behaviors? ___Yes ___No
Please describe _____
_____

List family history of mental illness/substance abuse:
Mother=MO Father=FA Sibling=S Grandmother=GM Grandfather=GF

Family History of:	Currently	In the Past	Never
Substance Abuse			
Anxiety			
Depression			
Manic Depression (Bipolar)			
Suicide Attempt			
Death by suicide			
Nervous Breakdown			
Addictive Behaviors (eating, sexual, etc.)			
Psychiatric Hospitalizations			

Do any of these illnesses significantly challenge or limit client's ability to function at work or home?
If yes, please explain: _____
_____

Is there anything further that you would like to add in regard to your overall history?
_____
_____
_____

Goals for Therapy: Please list what therapeutic outcomes you would like to have at discharge.
_____
_____
_____

By signing below I am indicating that the above information is accurate to the best of my ability.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

For Office Use Only:

_____ _____
Therapist's Signature/Credentials Date
Revised 06/25/2011

Case #_____