

Positive

Mind

Therapy

Client Intake Form

Please provide the following information about your child:

Full Name: Click here to enter text.

Nick Name: Click here to enter text.

Today’s Date: Click here to enter a date.

**Behavioral Excesses:**

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

**Behavioral Deficits:**

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

**Behavioral Assets:**

What does your child do that you like? What does he/she do that other people like?

**Others Concerns:**

Do you have any other concerns about your child or your family that you have not mentioned yet?

**Treatment Goals:**

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: What does that behavior look like, and what would it look like for you to be satisfied?

**Family History:**

The name of the child's biological parents:

Mother: Click here to enter text. Father: Click here to enter text.

Who has legal guardianship of your child?

Who are other household members with your child?

**Names Ages Relationship to child**

Who are your child's significant others NOT living with your child?

**Names Ages Relationship to child**

Please describe any past counseling of either your child or any family member. Click here to enter text.

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? Yes No If yes, please describe: Click here to enter text.

**Education History:**

What school does your child attend? Click here to enter text.

Phone:

Current Grade:

What does your child's teachers say about him/her? Click here to enter text.

Other schools attended (including pre-school):

Has your child ever repeated a grade? If so which one(s)?

Has your child ever received special education services? Yes No

Has your child experienced any of the following problems at School?

Fighting Lack of friends Drug/Alcohol Detention

Suspension Learning Disabilities Poor attendance Poor grades

Gang influence Incomplete homework Behavior problems Other Click here to enter text.

**Medical History:**

What is the name of your child's primary care physician?

Address: Phone:

Date of your child's last medical examination: Click here to enter a date.

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems?

A serious accident Hospitalization Surgery Asthma

A head injury High fever Convulsions/seizures

Eye/ear problems Meningitis Hearing problems

Allergies Loss of consciousness Other Click here to enter text.

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

**Other History:**

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?

If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and

his/her family?