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CHILD INTAKE FORM

CHILD
1. Child's Name_____ Sex_____ Age_____ DOB_____
2. Natural Child Yes / No If adopted, at what age_____ Foster since _____
3. Parent's Names (include step-parents, foster parents, inc.)
_____
_____
4. Comments about custody and visitation (if applicable):
_____
_____
5. Primary reason you are concerned about your child?
_____
_____
_____

SYMPTOM/PROBLEM CHECKLIST
Check any symptom that is a concern. How long has it been a problem?

a. Sleep problems____ Morbid thoughts____
Lack of interest in activities____ Suicidal thoughts or threats____
Unassertive____ Suicidal plans / attempts____
Fatigue/low energy____ Mood swings____
Concentration problems____ Depression____
Appetite/weight changes____ Changed level of activity____
Withdrawal____ Cries easily____

b. Forgetful/memory problems____ Talks excessively / interrupts____
Short attention span____ Easily distracted____
Aggressive behavior____ Irritable____
Can't sit still____ Impulsive____
Not interested in peers____ Difficulty following rules____
Picked on / bullied by peers____ Problem completing schoolwork____

c. Excessive worry / fearfulness ____Nightmares____
Anxiety or panic attacks____ Frequent tantrums____
Social fears, shyness____ Resistive to change____
Separation problems____ School refusal____
Bedwetting / soiling____ Perfectionism____
Headaches, stomachaches____ Odd hand / motor movements____
Odd beliefs / fantasizing____ Hallucinations____
d. Lying ____Stealing____

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Trouble with the law____ Being destructive____
Running away____ Fire setting____
Truancy, skipping school____ Hurting others / fighting____
Hurting others sexually____ Acts as if has no fear____
Alcohol / drug use____ Short tempered____
Argumentative / defiant____ Easily annoyed / annoys others____
Swears____ Discipline problem____
Blames others for mistakes____ Angry and resentful____

Brothers and Sisters
First Name – Last Name Sex Age Relationship to child (full, step,half, foster)
1.
2.
3.
4.
5.
6.

SCHOOL HISTORY

1. Present School: _____ Grade: ____ Teacher:_____
2. Has child ever repeated any grade? _____
3. Is child in special education services? Yes No, 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)
_____

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2. Developmental History
State the 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: ___ Separation from mother, ___ Out of home care, ___ Disruption in bonding, ___ Depression of mother, ___ Abuse, ___ Neglect, ___ Chronic pain, ___ Chronic Illness, ___ Parental Stress

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 medications
_____

List any medicines previously used for emotional problems: were they helpful? _____
_____
Allergies to drugs or medicines? No ____ Yes ____ (list) _____
Allergies to any foods? No ____ Yes ____(list) _____
Are there any foods that you limit or do not give this child? No ____ Yes ____
(list) _____
Allergies to environmental conditions? No ____ Yes ____(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 ____

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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 the immediate or extended family (Ex: Depression, anxiety, bipolar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

Has child witnessed domestic violence? __Y, __N, 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? __Y, __N, __Suspected. Specify:
2. Has your child been physically abused? __Y, __N, __Suspected. Specify:
3. Has your child been sexually abused? __Y, __N, __Suspected. Specify:
4. Other stressors or traumas?

What are your child's strengths?
Any additional comments or information that would be helpful to us?

Signature of person completing form/relationship to the client:

_____ Date: _____
Name Relationship

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