

## Child Information Intake Form

Please print throughout this form. All information is protected as confidential.

1. Child's Full Name: ..... Date: .....

2. Problem Identification—Which of these issues are current problems for your child?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Mood Swings              | <input type="checkbox"/> Conflicts with parents   | <input type="checkbox"/> Panic Attacks        |
| <input type="checkbox"/> Communication Problems   | <input type="checkbox"/> Conflicts with siblings  | <input type="checkbox"/> Repetitive behaviors |
| <input type="checkbox"/> Anger/Irritability       | <input type="checkbox"/> Academic/School Problems | <input type="checkbox"/> Sleeping Problems    |
| <input type="checkbox"/> Depressed Mood           | <input type="checkbox"/> Peer/Social Problems     | <input type="checkbox"/> Sleeping alone       |
| <input type="checkbox"/> Sadness                  | <input type="checkbox"/> Shyness/social avoidance | <input type="checkbox"/> Separation Anxiety   |
| <input type="checkbox"/> Loneliness               | <input type="checkbox"/> Lack of Motivation       | <input type="checkbox"/> Suicidal Thoughts    |
| <input type="checkbox"/> Fighting                 | <input type="checkbox"/> Lack of Personal Goals   | <input type="checkbox"/> Alcohol/Drug Use     |
| <input type="checkbox"/> Eating problems          | <input type="checkbox"/> Grief/Bereavement        | <input type="checkbox"/> Abuse/Abuser Issues  |
| <input type="checkbox"/> Self-confidence          | <input type="checkbox"/> Sex or Gender Issues     | <input type="checkbox"/> Self-harm            |
| <input type="checkbox"/> Feelings of Hopelessness | <input type="checkbox"/> Anxiety/Nervousness      | <input type="checkbox"/> Legal Problems       |
| <input type="checkbox"/> Other .....              |   |   |

3. Person to call in case of emergency: .....

Relationship: .....

Phone Number: .....

4. Has your child ever been in therapy before?  Yes  No If yes, explain: .....

5. What grade is your child in now? \_\_\_\_\_

6. Is your child classified with a learning disability?  Yes  No

If yes, in what grade was he/she first classified? \_\_\_\_\_

7. Is your child in need of extra help in school?  Yes  No If yes, explain: .....

8. Overall, what type of marks does your child achieve in school? .....

9. What is his/her strongest area in school? .....

10. What activities in school does he/she enjoy and excel at? .....

11. How often does your child experience peer problems in school?

- never  sometimes  often  very often

Print your child's full name here: .....

12. Was your child ever retained in a grade?  Yes  No If yes, in what grade/s? .....

13. Do you believe your child has any cultural or ethnic issues that need to be explained in order for therapy to be effective?

Yes  No If yes, explain:.....  
.....

14. Was your child ever abused by anyone?

Yes  No  physically  emotionally  sexually

If yes, what was his/her age at the time of the abuse? .....

Who was the perpetrator? .....

15. Is your child adopted?  Yes  No If yes, at what age was he/she adopted? .....

16. Is your child's family a stepfamily?  Yes  No

17. Are both biological parents living?  Yes  No If no, explain:.....  
.....

18. Marital status of parents:

married  domestic partners  engaged  separated  divorced

Comments: .....

19. Who has **legal** custody of this child?  biological mother  biological father  other, explain:  
.....  
.....

20. Who has **physical** custody of this child?  biological mother  biological father  other, explain:  
.....  
.....

21. Are any of your child's family members alcoholic or an abuser of other drugs?

Yes  No If yes, please explain:.....  
.....

22. Do any family members have a significant illness, physical disability, or psychological problem?

Yes  No If yes, please explain:.....  
.....

Print your child's full name here: .....

23. To your knowledge has your child ever abused alcohol or other drugs (e.g. Marijuana, Heroin, Cocaine, Amphetamines, Tranquilizers)?

Yes  No If yes, explain: .....  
.....  
.....

24. Does your child have any friends who you are concerned about?

Yes  No If yes, explain: .....  
.....  
.....

25. Does your child use tobacco?  Yes  No

Cigarettes/# packs per day \_\_\_\_  Pipe  Cigar  Chewing  
 Other: .....

26. Does your child have gambling or compulsive shopping problems?

No  gambling  shopping  
 other, explain: .....  
.....

27. Has your child ever experienced, witnessed, or been confronted with an event that involved actual or threatened death or injury, or threat to the physical wellbeing of him/herself or others?

Yes  No If yes, explain: .....  
.....

28. What are your child's leisure time activities? .....  
.....

29. Is your child spiritual?  Yes, practices his/her religion  Yes, but not practicing his/her religion

Somewhat spiritual  No

Print your child's full name here: .....

30. This is the most important question on this intake form, so please complete it thoughtfully.  
What are your counseling goals for your child, in other words, what do you want to achieve as a result of having been in counseling, what outcomes do you want?

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Continue to next page

Print your child's full name here: .....

31. Which of the following medical disorders does your child presently have?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Cushing's disease    | <input type="checkbox"/> Multiple sclerosis      |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Parkinson's disease     |
| <input type="checkbox"/> Angina pectoris          | <input type="checkbox"/> Hypoglycemia         | <input type="checkbox"/> Pre-menstrual dysphoria |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Hypothyroidism       | <input type="checkbox"/> Premenstrual Syndrome   |
| <input type="checkbox"/> Cardiac arrhythmia       | <input type="checkbox"/> Infectious hepatitis | <input type="checkbox"/> Rheumatoid arthritis    |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Influenza            | <input type="checkbox"/> Syphilis                |
| <input type="checkbox"/> Chronic pain             | <input type="checkbox"/> Malignancies         | <input type="checkbox"/> Systemic lupus          |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Malnutrition         | <input type="checkbox"/> Ulcerative colitis      |

My child has none of the medical disorders listed above.

32. List any other significant current medical problems (for example, high blood pressure, diabetes, etc)

that your child has: .....

.....

.....

.....

33. During his/her birth were there any significant complications?  Yes  No If yes, explain: .....

.....

.....

.....

34. Please list all medications prescribed by a physician that your child is currently taking:

Currently not taking any medication

▶ Name of Medication: ..... Dosage: .....

What are you taking it for? .....

▶ Name of Medication: ..... Dosage: .....

What are you taking it for? .....

▶ Name of Medication: ..... Dosage: .....

What are you taking it for? .....

▶ Name of Medication: ..... Dosage: .....

What are you taking it for? .....

.....  
*Signature of parent or person authorized by law*

.....  
*Date*