CHILD INTAKE

Patient name: _____ Age: _____ Date of Birth: ____/____/_____

Name of person completing form: _____

Relationship to Child: _____ Today's Date: ____/____/_____

School: _____ Grade: _____

Race: _____ Ethnicity: _____

Parent: _____ Mother / Father / Guardian
(last name) (first name)

Parent: _____ Mother / Father / Guardian
(last name) (first name)

Parent relationship: ___ partners ___ married ___ separated ___ divorced ___ widowed

If separated or divorced, provide date of separation: _____

If widowed, date of death: _____

Sibling(s) (name/age): _____

Who suggested that you seek assessment and/or counseling for your child?

___ School teacher ___ School counselor ___ Myself as a caregiver ___ Other: _____

Describe the overall problem that led you to seek help for your child:

_____

_____

_____

My child has difficulty with a relationship in our family (parent, sibling, parent's partner): Yes No

If yes, who: _____

I have reason to suspect my child has been abused (emotionally, sexually, and/or physically): Yes No

If yes, please explain:_____

Describe your child's school experience:

_____

_____

Describe your child's interactions with his/her parents or guardians:

_____

_____

Describe your child's interactions with siblings:

_____

_____

Describe your child's ability to complete tasks and follow directions:

_____

_____

I would describe my child as: Independent Dependent

Explain: _____

_____

My child appears to have high levels of stress: Yes No

If yes, explain: _____

_____

Describe your child's sleep patterns:

_____

_____

Describe your child's eating patterns:

_____

_____

Describe your child's physical activity level:

_____

_____

Medical History

Birth: Duration of labor: _____

Type of delivery: _____

Difficulties: _____

How soon did the mother see baby? _____

Birth weight: _____

Infancy: Age of weaning: _____

Feeding problems? _____

Approximate age of walking: _____

Approximate age of talking: _____

Sleep problems? Yes No

If yes, please explain: _____

Any behavior such as head banging, rocking, etc.? Yes No

If yes, please explain: _____

Does your child have difficulty separating from his/her parents? Yes No

If yes, please explain: _____

Has your child had any severe, long-term illnesses or accidents? Yes No

If yes, please explain: _____

Is your child on any medication? Yes No

If yes, please explain: _____

Does your child have any digestive problems? Yes No

If yes, please explain: _____

Does your child have any allergies? Yes No

If yes, please explain: _____

Does your child have any physical pain? Yes No

If yes, please explain: _____

Does your child ever appear disoriented or dizzy? Yes No

If yes, please explain: _____

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate family member/relation affected.

Autism	Yes	No	_____
Attention Deficit	Yes	No	_____
Depression	Yes	No	_____
Anxiety Disorder	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____
Other			_____

Any other information you would like to share?

_____

_____

_____