Child Intake

Please provide the following information about your child:

Full Name: _____

Birth Date: _____ Today's Date: _____

Behavioral Concerns:
List any concerns with your child's behavior at home and at school.

_____

_____

_____

_____

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

_____

_____

What do you enjoy most about your child? What do they excel at?

_____

_____

Treatment Goals:
What are you hoping to accomplish in counseling with your child?

_____

_____

Family History:
The name of the child's biological parents:

Mother: _____ Father: _____

Who has legal guardianship of your child?

Who are other household members with your child?

Names	**Ages**	**Relationship to child**

Please describe any past counseling that either your child or any family member:

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____ if yes, please describe:

Education:
What school does your child attend?

Current Grade: _____

City, State: _____

Phone: _____ Teacher's Name: _____

How is your child’s academic performance?

Has your child ever received special education services?

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	

Medical History:

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

City, State: _____ Phone: _____

Date of your child's last medical examination: _____

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

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?