Creating Hope Counseling

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CHILD'S INTAKE INFORMATION

Child's Name: _____ DOB: _____ Age _____

Address: _____ Phone: _____

Parents Name(s):_____ Phone: _____

School: _____ Phone: _____ Teacher: _____ Grade: ___

How does your child do in school academically? _____

How does your child do in school behaviorally? _____

Does your child have a learning disability? __ Yes __No __Maybe Specify_____

Does your family have specific spiritual beliefs? _____

Does your family attend church/temple? __ Yes __No Frequency _____

MEDICAL HISTORY

During pregnancy did mother use: __Cigarettes __ Alcohol __ Drugs __ Or have extreme stress

Specify frequency, amounts and duration: _____

List any birth complications (Ex.: premature, forceps delivery, jaundice, c-section, etc.) _____

_____

List any medical conditions or history (surgeries, broken bones, loss of consciousness, allergies, etc.)

_____

Does child use: __Cigarettes __ Alcohol __ Drugs Specify Amount & Frequency _____

Primary care physician: _____ Phone: _____

Current Medications (Include dosage and frequency) _____

Medication Allergies: _____

Other Allergies: _____

In the first two years did your child experience: __Separation from mother ___Parental Stress __ Abuse __Neglect __Out of Home Care __ Disruption in bonding __Depression of mother __Chronic Pain

If yes, please specify: _____
_____

Child reached developmental milestones: __ On Time __ Early __ Late
Please specify: _____

What are five adjectives that describe:

Mother _____

Father _____

Child _____

Parental Relationship _____

FAMILY INFORMATION

Biological Dad _____ DOB _____ Biological Mom _____ DOB _____

__ Married __ Separated __ Divorced

Siblings (Oldest to Youngest) _____ Age _____ _____ Age _____

_____ Age _____ _____ Age _____ _____ Age _____

Custodial Adults (if not biological parents):

_____ Relationship _____ Month & year joined family __/____

_____ Relationship _____ Month & year joined family __/____

Does father work outside the home? __ Yes __ No Hours: _____

Does mother work outside the home? __ Yes __ No Hours: _____

If separated or divorced, visitation schedule: _____

Does either parent have legal issues? _____

Number of moves child has made: _____

List any history of mental illness or addiction in immediate or extended family (Ex.: Depression, anxiety, suicide attempts, manic-depression, alcoholism, drugs, ADHD, etc.) _____
_____

Have children witnessed parental arguments? __ Yes __ No Specify _____

_____
Have children witnessed domestic violence? __ Yes __ No Specify _____

_____

How is your child disciplined?

Method _____ Frequency _____

Method _____ Frequency _____

Method _____ Frequency _____

Method _____ Frequency _____

TRAUMA HISTORY

Has your child been verbally abused? __Yes __No __Suspected Specify _____

Has your child been physically abused? __Yes __No __Suspected Specify _____

Has your child been sexually abused? __Yes __No __Suspected Specify _____

Other stressors or traumas? _____

_____

_____

CHILD'S PREVIOUS MENTAL HEALTH PROVIDERS:

Name: _____ Dates_____ Issue or Diagnosis _____

Name: _____ Dates_____ Issue or Diagnosis _____

Circle symptoms your child has and number of times per week.

Anger	Depression	Sleeps too much	Acts out sexually with others
Conduct Problems	Anxiety	Bedwetting	Unusual or explicit sexual knowledge
Day Wetting	Controlling	Day Defecation	Masturbates excessively
Disassociates	Defiance	Alcohol Use	Plays out sexual themes
Hypervigilance	Drug Use	Impaired Conscience	Plays out violent themes
Lack of Motivation	Hyperactivity	Lack of empathy	Homicidal thoughts or actions
Low Impulse Control	Lethargy	Lying	Argues with adults
Nightmares	Night terrors	Obsesses	Somatic Symptoms
Peer Problems	Overeats	Phobias	Stomachaches, headaches, etc
Startles easily	Stealing	Tantrums	Suicidal thoughts or actions
Shy	Sleeplessness	Under eats	Running away

How does your child handle anger? _____

_____

What are your child's hobbies? _____

_____

What are your child's strengths? _____

_____

Briefly, what are your goals for your child's therapy? _____

_____

_____

_____

_____

_____

Please print name of person who filled out this form

_____ _____

Signature Date