Child intake Form

Child's Name:_____ Today's Date:_____

Child's age:_____ Date of Birth: _____

Address:_____

_____

Parent's Name: _____ Parent's Name: _____

Home phone:_____May I leave a message? Yes No

Cell phone:_____May I leave a message? Yes No

Work phone:_____May I leave a message? Yes No

Email: _____May I email you? Yes No

(For appointment scheduling purposes only, as email is not considered a confidential medium of communication).

Type of Insurance for referral purposes: _____

How did you hear about me? _____

Has your child ever received any mental health treatment in the past? Was this a positive experience for you and/or your child?

_____

_____

_____

_____

Please include the names of all previous mental health professionals that have worked with your family and approximate dates of care: _____

_____

_____

What are the main reasons you are seeking help for your child?_____

_____

_____

What is your hope doing our time together for you and your child? _____

_____

_____

Has your child ever mentioned or attempted wanting to end his or her life? Yes No

If yes, is your child currently suicidal? Yes No

Has your child ever mentioned hurting themselves or struggled with self-harm? Yes No

Has your child ever been hospitalized for a mental health related condition? Yes No

Does your child exercise regularly? Yes No

Does your child eat well? Yes No

Does your child sleep 6 to 8 hours/night? Yes No

Have you ever suspected or are aware of any alcohol or drug use by your child? If so what kind and how often? _____

_____

_____

Do you or any family member consider his or her drug use to be a problem? _____

Please list your child's prescription medication and dosage: _____

_____

_____

Any other general health information you would like me to know about? _____

_____

_____

Has your child ever experienced any trauma including difficult pregnancy, birth, early childhood trauma, or the loss of a loved one? If yes, please explain: _____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Psychiatric Hospitalizations	Yes No	

YOUR CHILD'S FAMILY:

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody (if divorced)? _____

Please describe the current visitation schedule (if any) and type of communication with child's other parent: _____

Are there any step-parents involved in your child's life? If so, please include names:

_____

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

School name: _____

Does your child enjoy school? _____

How much are <u>each</u> of the following areas currently a struggle for your child?

	Not at all	**A little**	**Somewhat**	**Considerably**	**Terribly**
	1	**2**	**3**	**4**	**5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: _____

_____

_____

_____

_____