CHILD INTAKE FORM

**The following information is being requested for the therapeutic treatment of a child/teen. The more information and history we can obtain from you, the more effective our care can be. We appreciate you taking the time and energy to be as thorough as you are able to be.**

**Child/Adolescent Intake Information for ______________________________**

**Person who is filling out this form _________________________**

**Date this Form was completed _____________________________**

| **Place of Birth** | |
|---|---|
| **Date of Birth** | |
| **Adoptive Parents Names** | |
| **Biological Parents** | |
| **Guardian** | |

| **Child Currently Lives at ….**<br><br>**Address:** ____________________________<br><br>____________________________________ | **Child Currently Lives with**<br>______________________________________<br><br>______________________________________ |
|---|---|
| **Siblings In Home** | |
| **Childcare Placement** | |
| **Child Foster Care Placement** | |
| **Child Abuse Case Worker (County)** | |
| **Physician / Clinic of Care** | |
| **Allergies** | |
| **Medical Health History/ Diagnosis** | |

| | |
|---|---|
| | |
| **Mental Health History/ Diagnosis** | |
| **Medications Currently Taking / How often** | |
| **Alternative Care Providers** | |
| **Current Supplementation/Vitamin** | |
| **Childhood /Teen Traumatic Experiences** | |
| **Domestic Abuse Child has Been Exposed to:** | |
| **Death / Loss Experienced** | |

| **Household Member Name** | **Relationship to Child** | **Age** | **Occupation/School** | **Highest level of Education** | **Quality of Relationship** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

## Custody Arrangements

- Lives with Mother _____ % of the time
- Lives with Father ______% of the time
- Lives with Both Parents yes no
- Other ___________________________________________

**Is there a Parenting Plan? YES NO Dated: ____________________________**

## Developmental Issues

| | |
|---|---|
| Pregnancy Complications with mother? | |
| Use of Chemicals by Mother During Pregnancy | |
| Medical concerns or injuries of mother during pregnancy | |
| Family trauma and/or losses during pregnancy | |
| Weight loss during pregnancy? | |
| Smoking during pregnancy? | |
| Birthing Complications? | |

| | | |
|---|---|---|
| Born Prematurely | Yes | No |
| Born with Chord around The Neck | Yes | No |
| Trouble Breathing | Yes | No |
| Incubated for longer than a couple of hours | Yes | No |
| Infections at Birth | Yes | No |
| Other Problems at Child's Birth? | | |
| Medical Diagnosis at Birth | | |

## Childhood Development Details

| | **Check for Yes** | **Check for No** |
|---|---|---|
| **Constipation** | | |
| **Stomach Aches** | | |
| **Trouble Falling Asleep** | | |
| **Trouble Staying Asleep** | | |
| **Over-activity** | | |

| **Head banging** | | |
|---|---|---|
| **Rocking in Bed** | | |
| **Temper Tantrums** | | |
| **Self-Destructive Behavior** | | |
| **Difficulty in being comforted or consoled** | | |
| **Stiffness or rigidity** | | |
| **Aloof** | | |
| **Crying often and easily** | | |
| **Shyness with Strangers** | | |
| **Irritability** | | |
| **Extreme reactions to noise or sudden movement** | | |
| **Poor Eating Habits** | | |
| **Only Eats a Few Items** | | |
| **Opposes Directions** | | |
| **Lashes Out** | | |
| **Little Energy** | | |
| | | |

## Attention and Focus

| **Focus and Attention** | **Check for Yes** | **Check for No** |
|---|---|---|
| Can concentrate for short amounts of time (10 minutes) | | |
| Can concentrate for a fair amount of time (20 to 30 minutes) | | |
| Does what is asked and asks questions as needed | | |
| Learns a skill one day and can't recall it days later | | |
| Fidgets and is Easily Distracted | | |
| Memory Concerns<br>**Attention and Focus Continued** | **Check if YES** | **Check if NO** |
| Needs constant Attention Needs Supervision to Complete Tasks | | |
| Very Independent/Calm | | |
| Cannot Sit Still | | |
| Inquisitive | | |
| Easily Bored | | |
| Daydreams | | |
| Pleasant Conversationalist | | |

| | | |
|---|---|---|
| Enjoys Learning | | |
| Often Makes Mistakes that are Unnecessary | | |
| Rages at Others | | |
| Often Confused | | |
| Complains of Body Aches or Pain | | |
| Struggles to have Relationships | | |
| Competitive | | |
| Blurts out Answers and Interrupts Often | | |
| Trouble with the Law | | |
| Hurts himself/herself | | |
| Uses Chemicals | | |
| | | |

## School History and Functioning Information

If Educational Services are Provided, Who is overseeing the progress?
___________________________________________________________________

## Check the following if they apply:

Early Childhood Special Education ___
Special Learning Disability ___
Visual Impairment ___
Physically Impaired ___
Cognitive Disorder ___
Autism Spectrum Disorder ___ ______________________________
Traumatic Brain Injury ___ ______________________________

Developmental Delay Diagnosis ___
Hearing Impaired ___
Speech or Language Impairment ___
Emotional/Behavioral Disorder ___
Special Learning Disability ___

**Current School Plans** ____________________________________________

## School Information

| | |
|---|---|
| School Attending | |
| Grade | |
| Teacher Name (s) | |
| Gifted, Home-Schooled, Tutored, Outside Educational Programs, District Support Services | |
| | |

| **ATHLETIC ACTIVITIES AND HOBBIES** |
|---|
| |

## Legal History

**Shoplifting/Damage to Property? Yes NO?**

**Running Away? YES NO Juvenile Detention? Yes When? NO**

**Charges YES When? Where? What for?**

**Charges YES When? Where? What for?**

**Youth Services Bureau Involvement Yes When? No**

**This Child has been incarcerated Yes When? No**

## Traumatic Experiences and Treatment

| Trauma | When | By Whom |
|---|---|---|
| Physical Abuse | | |
| Sexual Abuse | | |
| Emotional Abuse | | |
| Bullying | | |
| Parental Abandonment | | |
| Domestic Abuse Exposure | | |
| Parental Abuse Exposure | | |
| Community Violence | | |
| Suicide | | |
| Murder | | |

### Medical and Mental Health Treatment History

**My child/teen has received mental health therapy at (clinic):**
________________________________________

**Treating Therapist/Evaluator/Doctor:** ________________________________________________________

**Reason for Visit** ___________________________________________________________________________

**Time of Treatment:** _______________________________ **ROI NEEDED**________

**Diagnosis Given:** ____________________________________________________________________

**Tests Completed:** ____________________________________________________________________

**Medications Prescribed** _______________________________________________________________

**My child/teen has received mental health therapy at (clinic):**
______________________________________

**Treating Therapist/Evaluator/Doctor:** ____________________________________________________

**Reason for Visit** ______________________________________________________________________

**Time of Treatment:** ______________________________ **ROI NEEDED**________

**Diagnosis Given:** ____________________________________________________________________

**Tests Completed:** ____________________________________________________________________

**Medications Prescribed** _______________________________________________________________

**My child/teen has received mental health therapy at (clinic):**
______________________________________

**Treating Therapist/Evaluator/Doctor:** ____________________________________________________

**Reason for Visit** ______________________________________________________________________

**Time of Treatment:** ______________________________ **ROI NEEDED**________

**Diagnosis Given:** ____________________________________________________________________

**Tests Completed:** ____________________________________________________________________

**Medications Prescribed** _______________________________________________________________

## Relationships

| | | |
|---|---|---|
| Child/Adolescent Gets Along well with Mother | Yes | No |
| Child/Adolescent Gets Along well with Father | Yes | No |
| Child/Adolescent Gets Along well with Siblings | Yes | No |

Child/Adolescent Gets Along well with Grandparents Yes No

Child/Adolescent Gets Along well with Step Parent Yes No

Child/Adolescent Gets Along well with Teacher Yes No

Child/Adolescent Gets Along well with Friends Yes No

If my Child had his/her own way, they would ________________________________________.

I very much enjoy my child when we ____________________________________________.

The most difficult times we have are

______________________________________________________________________________

______________________________________________________________________________

Holidays are _______________________________________________________

This child is most like ______________________________ (who) in

_____________________________________________________________________ (ways).

Sometimes I feel like I should have done better at ____________________________________.

I blame __________________________ for ________________________________________.

I am most proud of my child/teen for _____________________________________________.

Other Helpful Information:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## Family History Information

| Health Problems | CHECK Yes | No | (Grand) Parent | Sibling | Other |
|---|---|---|---|---|---|
| Disability | | | | | |
| Legal Issues | | | | | |
| Alcohol | | | | | |
| Street Drugs | | | | | |
| Prescription Pills | | | | | |

| | | | | |
|---|---|---|---|---|
| Anxiety | | | | |
| Depression | | | | |
| ADHD/ADD | | | | |
| Bipolar | | | | |
| Schizophrenia | | | | |
| Psychosis | | | | |
| Violent Acting Out | | | | |
| Learning Disabilities | | | | |
| Sensory Disorder | | | | |
| Autism Spectrum | | | | |
| Developmental Disorders | | | | |

**Military Involvement**

Please describe military involvement in your family:

Parental Deployment Dates:

Changes and losses related to deployments:

Thank you very much for taking the time to share your personal information with me. I hope to help you improve your current circumstances that your family is facing. I will work diligently on your behalf to accurately evaluate, develop a plan, recommend resources and promptly initiate therapeutic services. If you have specific needs, cares or questions please don't hesitate to discuss it with me.

**Parent/Guardian Signature** **Date**