

**CHILD INTAKE FORM**  
**(Please complete in ink)**

**CHILD**

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Natural Child Yes/ No If adopted, at what age \_\_\_\_\_ Foster since \_\_\_\_\_

Parent's Names (include step-parents, foster parents)

\_\_\_\_\_  
\_\_\_\_\_

Comments about custody and visitation (if applicable):

\_\_\_\_\_  
\_\_\_\_\_

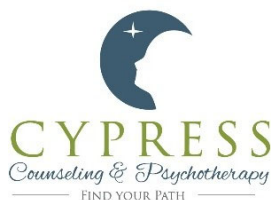
Primary reason you are concerned about your child?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SYMPTOM/PROBLEM CHECKLIST**

**Check any symptom that is a concern. How long has it been a problem?**

- |                             |                                |                               |
|-----------------------------|--------------------------------|-------------------------------|
| a.                          | Sleep problems                 | Morbid thoughts               |
|                             | Lack of interest in activities | Suicidal thoughts or threats  |
|                             | Unassertive                    | Suicidal plans / attempts     |
|                             | Fatigue/low energy             | Mood swings                   |
|                             | Concentration problems         | Depression                    |
|                             | Appetite/weight changes        | Changed level of activity     |
|                             | Withdrawal                     | Cries easily                  |
| b. <input type="checkbox"/> | Forgetful/memory problems      | Talks excessively/ interrupts |
|                             | Short attention span           | Easily distracted             |
|                             | Aggressive behavior            | Irritable                     |
|                             | Can't sit still                | Impulsive                     |
|                             | Not interested in peers        | Difficulty following rules    |
|                             | Picked on / bullied by peers   | Problem completing scr        |



Excessive worry / fearfulness  
 Anxiety or panic attacks  
 Social fears, shyness  
 Separation problems  
 Bedwetting / soiling  
 Headaches, stomachaches  
 Odd beliefs / fantasizing

Nightmares  
 Frequent tantrums  
 Resistant to change  
 School refusal  
 Perfectionism  
 Odd hand / motor movements  
 Hallucinations

c. Lying  
 Trouble with the law  
 Running away  
 Truancy, skipping school  
 Hurting others sexually  
 Alcohol / drug use  
 Argumentative / defiant  
 Swears  
 Blames others for mistakes

Stealing  
 Being destructive  
 Fire setting  
 Hurting others / fighting  
 Acts as if has no fear  
 Short tempered  
 Easily annoyed / annoys others  
 Discipline problem  
 Angry and resentful

**Brothers and Sisters**

First Name - Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

**SCHOOL HISTORY**

Present School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Has child ever repeated any grade? \_\_\_\_\_

Child in special education services? No \_\_\_\_\_ Yes, what kind? \_\_\_\_\_

Please describe academic or other problems your child has had in school

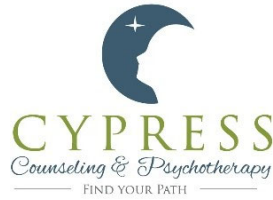
\_\_\_\_\_

**CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY**

**1. Pregnancy**

Mother used during pregnancy: alcohol \_\_\_ drugs \_\_\_ cigarettes \_\_\_

Delivery: Normal \_\_\_ Breech \_\_\_ Cesarean \_\_\_ Transactional \_\_\_  
 Full-term \_\_\_ Premature \_\_\_ if premature, number of weeks \_\_\_



Birth Weight: \_\_\_\_\_

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc.)

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## 2. Developmental History

- State approximate age when child did the following:  
Walked alone \_\_\_\_ Said first word \_\_\_\_ Used 2-word phrases \_\_\_\_
- Understood and followed simple directions \_\_\_\_
- Reasonably well toilet trained \_\_\_\_
- Did child cry excessively? \_\_\_\_ Rarely cried \_\_\_\_

## 3. Health History of Child

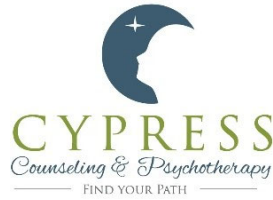
In the first two years, did your child experience:  Separation from mother,  
 Out of home care,  Disruption in bonding,  Depression of mother,  Abuse,  
 Neglect,  Chronic pain,  Chronic Illness,  Parental Stress

- Child's Doctor: \_\_\_\_\_
- Date of last physical exam: \_\_\_\_\_
- Vision problems? Yes \_\_\_\_ No \_\_\_\_ Hearing problems? Yes \_\_\_\_ No \_\_\_\_
- Dental problems? Yes \_\_\_\_ No \_\_\_\_
- Any head injuries or loss of consciousness?
- Child's history of serious illness, injury, handicaps, or hospitalization?  
No \_\_\_\_ Yes - describe and give dates \_\_\_\_\_
- Is your child currently taking any medications? No \_\_\_\_ Yes \_\_\_\_ name medications:

- List any medicines previously used for emotional problems: were they helpful? \_\_\_\_  
\_\_\_\_\_
- Allergies to drugs or medicines? No \_\_\_\_ Yes \_\_\_\_ (list)\_\_\_\_\_
- Allergies to any foods? No \_\_\_\_ Yes \_\_\_\_ (list)\_\_\_\_\_
- Are there any foods that you limit or do not give to your child? Yes \_\_\_\_  
No \_\_\_\_ (list)\_\_\_\_\_
- Allergies to environmental conditions? No \_\_\_\_ Yes \_\_\_\_ (list)\_\_\_\_\_
- Does anyone in the household smoke? No \_\_\_\_ Yes \_\_\_\_:
- About how many hours does this child watch TV, videos, etc. per day\_\_\_\_\_
- Are you afraid someone you know may injure/harm this child? No \_\_\_\_ Yes \_\_\_\_  
National Domestic Violence Hotline 1-800-799-7233
- Does this child have a Health Care Directive? No \_\_\_\_ Yes \_\_\_\_  
If yes, please list where (clinic) it is on file\_\_\_\_\_
- Any previous psychological or psychiatric treatment? No \_\_\_\_ Yes \_\_\_\_  
Whom/where\_\_\_\_\_when\_\_\_\_\_
- Any previous testing (school/psychological)? No \_\_\_\_ Yes \_\_\_\_  
Whom/where\_\_\_\_\_
- Do you think your child's use of chemicals is a problem? No \_\_\_\_ Yes \_\_\_\_  
Type: Alcohol \_\_\_\_ Marijuana \_\_\_\_ Other drugs\_\_\_\_\_
- Comments: \_\_\_\_\_

**Family History:**

Chemical use (now & past): No \_\_\_\_ Yes \_\_\_\_ Which parent \_\_\_\_\_  
Type: Alcohol \_\_\_\_ Marijuana \_\_\_\_ Other drugs.\_\_\_\_



List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

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Has child witnessed domestic violence?  Y  N, Specify: \_\_\_\_\_

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How is your child disciplined? Please list each method and frequency of use: \_\_\_\_\_

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### **LIFE STRESSORS/TRAUMA HISTORY**

1. Has your child been verbally abused?  Y,  N,  Suspected. Specify: \_\_\_\_\_

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2. Has your child been physically abused?  Y,  N,  Suspected. Specify: \_\_\_\_\_

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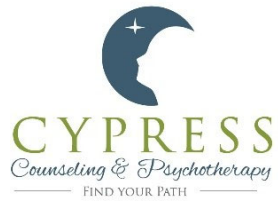
3. Has your child been sexually abused?  Y,  N,  Suspected. Specify: \_\_\_\_\_

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4. Other stressors or traumas? \_\_\_\_\_

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What are your child's strengths?



Any additional comments or information that would be helpful to us?

Signature of person completing form/ relationship to client:

\_\_\_\_\_ Date: \_\_\_\_\_  
Name Relationship