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FIND YOUR PATH

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
- Lack of interest in activities
- Unassertive
- Fatigue/low energy
- Concentration problems
- Appetite/weight changes
- Withdrawal
- Morbid thoughts
- Suicidal thoughts or threats
- Suicidal plans / attempts
- Mood swings
- Depression
- Changed level of activity
- Cries easily

b. __
- Forgetful/memory problems
- Short attention span
- Aggressive behavior
- Can't sit still
- Not interested in peers
- Picked on / bullied by peers
- Talks excessively/ interrupts
- Easily distracted
- Irritable
- Impulsive
- Difficulty following rules
- 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
Resistive 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 ___

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Birth Weight: _____

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

_____

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:

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- 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.___

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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.):

_____

_____

Has child witnessed domestic violence? _Y _N, Specify:_____

_____

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

_____

_____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? _ Y, _N, _Suspected. Specify:_____

_____

2. Has your child been physically abused? _Y, _N, _Suspected. Specify:_____

_____

3. Has your child been sexually abused? _Y, _N, _Suspected. Specify:_____

_____

4. Other stressors or traumas? _____

_____

What are your child's strengths?

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

Signature of person completing form/ relationship to client:

_____ Date:_____

Name Relationship