**Child Intake**

Child’s Name Date

Birthdate: Age:

Caregiver **#1** Name: Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |   |  (home) |  (work) |  |
| Okay to call you at home? |  |  | Okay to leave messages at home? |  |  |
| Okay to call you at work? |  |  | Okay to leave messages at work? |  |  |
| EMAIL ADDRESS: |  |  |  |
| Okay to email regarding scheduling? |  |  |  |  |  |
|  |  |  |  |  |  |
| Okay to email regarding billing? |  |  |  |  |  |  |

Address:

City State Zip County

Caregiver **#2** Name Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  (home) |  (work) |  |
| Okay to call you at home? |  |  | Okay to leave messages at home? |  |  |
| Okay to call you at work? |  |  | Okay to leave messages at work? |  |  |
| EMAIL ADDRESS: |  |  |  |
| Okay to email regarding scheduling? |  |  |  |  |  |
|  |  |  |  |  |  |
| Okay to email regarding billing? |  |  |  |  |  |  |

Address

City State Zip County

*\*For children who share time between households, it is helpful for each caregiver to fill out a separate packet.*

**Child**

Please use the lines below to describe your child:

**Family**

Who are the members of your household? Please list names and ages (including pets):

Please list some family strengths:

What ways does your family like to share time together?

Please list any current family stressors:

What role does extended family play in your life?

Please list the names and ages of your child’s grandparents, aunts, uncles, cousins. If your family is too large to name all members, please feel free to list only grandparents and other members closest to you child:

Maternal (Mother’s Side)

Paternal (Father’s Side)

*Please place a checkmark next to the different parenting methods you tend to use in working to shape your child’s behavior and character:*

 Praise Loss of Privileges Time-out/Grounding

 Rewards Parent-Child Quality Time Chores/Contributing to Family

 Emotional Coaching Teaching

Please briefly describe what you hope to accomplish through your parenting:

I believe a strong relationship with our children is the key ingredient to effective parenting, and for that reason, often involve parents in the process of their child’s therapy. Parent-child sessions allow for increased connectedness and understanding to grow between you and your child. Parent-only sessions give you a safe space to address any concerns you may be having about your child, or family, and receive new ideas for how you may be able to approach a stuck spot.

Please briefly describe your feelings about being included in the therapeutic process and any questions or concerns you have related to this approach:

**Development:**

Child’s approximate due date: Birth date:

Birth and delivery story:

Was your child breast fed or bottle fed? Until what age?

Where was your child’s first home?

Did your child receive care by a child care provider?

If so, please list the name of providers below as well as the approximate timeframe in

which they cared for your child:

Did your child develop typically? If not, please indicate areas where development was outside the typical range

**Academic:**

What are your child’s favorite subjects in school?

Do you have any school-related concerns?

During the past year has your child received any special services within the school for attention, behavior, learning, or emotional difficulties?

Does your child have an IEP? If so, when was it last reviewed?

**Friendships:**

Does your child have a friend his/her age who he/she hangs out with?

What types of activities does your child tend to be active in when spending time with their peers?

Do you have any concerns with regard to your child’s ability to make or maintain friendships?

**Extracurricular:**

Does your child participate in any extracurricular activities (sports, clubs, music, art, etc.)? If so, which ones?

How do you see your child impacted through these extracurricular involvements?

What is the time commitment tied to the above activities?

**Health**

When was your child’s last medical exam?

Is your child on medication for the treatment of any physical or mental health problems?

If so, please list the name of the treating physician and the medication(s) prescribed:

Physician: Medication(s)

Physician: Medication(s)

*Place a checkmark next to any of the following problems your child has experienced during the past year:*

Wetting the bed? Soiling him/herself during day hours?

Frequent headaches or stomach aches? Difficulty sleeping?

Nightmares? Getting stuck on one idea or repeating a behavior over and over?

Describe any of the problems checked above:

Do you have any concerns about your child’s eating habits?

If so, what are they?

**Behavioral**

*Place a checkmark next to the following behaviors/activities that your child engages in regularly:*

|  |  |  |
| --- | --- | --- |
| Breaking rules | Stealing | Failing to complete school |
| Arguing | Starting fires | Work/Job |
| Asking for help | Expressing emotion | Lying |
| Losing his/her temper | Skipping school | Expressing needs |
| Not following directions | Biting | Crying |
| Sharing | Hitting/Kicking | Talking excessively |
| Asking questions | Using feeling words | Sleeping excessively |
| Running away |  Spending time alone |  |

**Emotional/Psychological**

Has your child had difficulties with excessive worrying or fears?

If so, what does he/she tend to worry about or be fearful of?

Does this problem interfere with his/her life?

If so, in what ways?

Have you noticed your child experience several days at a time when he/she feels sad or depressed?

If so, describe:

Have you noticed your child experience a decrease in interest around things he/she usually likes to do?

If so, when did this begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What specific changes did you notice?

**Stressors**

*Please place a checkmark next to any of the following stressors your child or family has encountered, as well as the approximate date(s) surrounding their occurrence.*

Unemployment of a parent Date(s):

Divorce of parent(s) Date(s):

Death of a loved one Date(s):

Serious Illness Date(s):

Physical Abuse Date(s):

Sexual Abuse Date(s):

Emotional/Verbal Abuse Date(s):

Eviction from home Date(s):

Legal problem Date(s):

Hospitalization Date(s):

A move or change of households Date(s):

Others:

Has your child ever had a terribly frightening experience in which he/she was in danger of being killed or badly hurt?

If so, please describe the experience:

**Additional Concerns/Thoughts**

On the lines below, please list any additional concerns:

I will know therapy is working when:

I will know my child and family are ready to be done with therapy when:

**ISSUES INVENTORY Name**

**Below you will find a list of problems people frequently need help with.**

**Look down the list and rate yourself as to the degree of severity that each subject presents.**

**Check the numbers from 1 (no problem) to 5 (severe problem) that apply.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **No Problem** |  |  |  | **Severe** |
| **Subject** | **1** | **2** | **3** | **4** | **5** |

Crying for no Reason

Can’t enjoy myself

Feeling lonely

Feeling down/ depressed

Feeling hopeless

Low self-esteem/ self-confidence

Feeling unhappy about myself

Difficulty expressing feelings

Dealing with traumatic experiences

Feeling anxious

Feeling angry

Feeling out of control

Absentmindedness

Can’t make decisions

Intrusive thoughts

Difficulty concentrating

Racing Thoughts

Thinking about suicide

Thinking about hurting someone else

Trouble controlling aggression

Impulsivity or recklessness

Thoughts that confuse or scare me

Difficulty being assertive

Concerns re. use of pornography

Balancing responsibilities

Procrastination/ Lack of motivation

Problems with grades/ school work

Time management

Easily distracted

Disorganization

Test anxiety

Anxiety regarding public speaking

Perfectionism

Worried about future career

Feeling rejected by others

Trouble making or keeping friends

Difficulty with authority

Sexual issues

Racial/ethnic/cultural issues

Relationships with females

Relationships with males

Relationship with roommate/friend

Relationship with family

Relationship with romantic partner

Relationship with my children

Premarital

Substance use of family member

Substance use of friend

Own use of alcohol/drugs

Difficulty with sleep (sleeping too

much; difficulty falling asleep or

staying asleep)

Problems with eating

Struggles with body image

Please indicate below those parts of your life that give you pain or that you struggle with. Then show the desired change in yourself or your behavior that you wish to accomplish through therapy. Problems and struggles may involve internal factors such as thoughts, values, feelings, intentions, etc. Or the issues may involve external factors such as your relationships with others, school, jobs, etc.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Problem** |  |  | **Desired Change** |  |  |
|  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |



After making your list above, please go back and number the problems in order of importance to you (with “1” being most important).