Child Intake

Child's Name_____Date_____

Birthdate_____Age_____

Caregiver Name_____Telephone_____/_____
(home) (work)

Okay to call you at home? Yes No Okay to leave messages at home? Yes No
Okay to call you at work? Yes No Okay to leave messages at work? Yes No

EMAIL ADDRESS:_____
Okay to email regarding scheduling? Yes No
Okay to email regarding billing? Yes No

Address_____

_____

City State Zip County

Caregiver Name_____Telephone_____/_____
(home) (work)

Okay to call you at home? Yes No Okay to leave messages at home? Yes No
Okay to call you at work? Yes No Okay to leave messages at work? Yes No

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

_____
_____
_____
_____
_____

Paternal

_____
_____
_____
_____
_____

Please circle 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

Parent-Child quality time Rewards 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 often 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 his/ her 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.)?_____
_____
_____

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)_____

During the past year has your child had problems in any of the following areas?

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?_____
If so, describe:_____
Do you have any concerns about your child's eating habits?_____
If so, what are they?_____

Behavioral

Please underline any of the following behaviors that your child engages in regularly:

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

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?_____
_____
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 circle 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_____
Divorce of parent(s)_____
Death of a loved one_____
Serious Illness_____
Physical Abuse_____
Sexual Abuse_____
Emotional/Verbal Abuse_____
Eviction from home_____
Legal problem_____
Hospitalization_____
A move or change of households_____
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

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_____Date_____**

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.

Subject	No Problem 1	2	3	4	Severe 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 re. 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.