Child Intake

Child's Name				Da	ate			
Birthdate	Ag	ge						
Caregiver Name			_Telephon	ie				
Okay to ca	Ill you at home? Y Ill you at work? Y S:	les N	o Okay	to leave	(home) messages at messages at	home?	Yes	
Okay to er	nail regarding sche nail regarding billi	duling			_			
Address								
City	State		Zip		County			
Caregiver Name						/		
Okay to ca	Ill you at home? Y Ill you at work? Y	es No	o Okay	to leave	(home) messages at messages at	home?	Yes	
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

Ple	ease (circle th	he a	lifferent	par	enting	r methods	you	tend	to u	ise in	working	to	shape	your	child	's
be	havio	or and c	har	racter:	-	0						0		-			
-			-	0				_									

Praise	Loss of privileges	Time	e-out/ Grounding
Parent-Child qu	ality time	Rewards	Chores/ Contributing to family
Emotional coacl	hing	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?

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:

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	n?
Is your child on medication for the treatm	ent of any physical or mental health problems?
If so, please list the name of the treating p	physician and the medication(s) prescribed:
Physician	Medication(s)
Physician	Medication(s)
During the past year has your child had p	problems in any of the following areas?
Wetting the bed? Soi	ling him/herself during day hours?
Frequent headaches or stomach aches?	Difficulty sleeping?
Nightmares?	
Getting stuck on one idea or repeating a b	behavior over and over?
If so, describe:	
Do you have any concerns about your chi	ld'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
Arguing	Starting fires	work
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

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 INVENTOR	Y Name	Date
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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.

Subject12345Crying for no Reason </th <th></th> <th>No Prob</th> <th>olem</th> <th></th> <th></th> <th>Severe</th>		No Prob	olem			Severe
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Feeling down/ depressedImage: Constraint of the second	Can't enjoy myself					
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Test anxiety		1				
Anxiety re. public speaking	Disorganization	1				
Perfectionism	Test anxiety	1				
	Anxiety re. public speaking	1	1			
Worried about future career	Perfectionism	1				
	Worried about future career	1				

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.