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Child Intake Form

Child's name: _____ Child's date of birth:_____ Child's SS#:_____ Age:_____

Child's grade level and name of school: _____

Does child have an IEP or 504 plan (Please circle)?: Yes or No

Child's religious background: _____

Child's parent(s)/guardian(s):_____

Child's Address: _____

Child's home phone:_____ Child's cell phone:_____

Is it okay to call and leave voice message at home? _____ On cell?_____

Current or history of DCYF involvement (Please circle)?: Yes or No

Mother's name: _____ Mother's Age:_____

Mother's occupation:_____ Mother's employer:_____

Mother's religious affiliation:_____ Mother's home phone:_____

Mother's cell phone:_____ Mother's work phone: _____

Is it okay to call and leave voice message at home? _____ At work?_____ On cell?_____

Mother's marital status (Please circle): married/re-married/ engaged/ widowed/ divorced/ separated/ live with partner/ other:

*If parents living apart then please fill in the address blank below:

Mother's address: _____

Father's name: _____ Father's age:_____

Father's occupation:_____ Father's employer:_____

Father's religious affiliation:_____ Father's home phone:_____

Father's cell phone:_____ Father's work phone: _____

Is it okay to call and leave voice message at home? _____ At work?_____ On cell?_____

Father's marital status (Please circle): married/re-married/ engaged/ widowed/ divorced/ separated/ live with partner/ other:

In case of emergency who should be notified?
Name:_____Address:_____
Phone:_____ Relation:_____

Child Intake Form Continued (to be completed with parent)

Referred by: _____

Name of Health Insurance Policy (if using):_____

Policy Number:_____ Policy Holder's Name:_____

Policy Holder's DOB:_____ Policy Holder's SS#:_____

Family Composition: Please list names and ages of all individuals who reside in the same household as your child (half or step siblings to be included).

Name: _____ Age:_____ Relationship:_____

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Name: _____ Age:_____ Relationship:_____

Has your child received counseling before (Please circle)? Yes or No

Counseling/Therapist Name: _____ Dates from/to:_____

Outcome and Diagnosis: _____

Name and number of Primary Care Physician:_____ Date of last medical exam:_____

Any previous medical and/or psychiatric hospitalizations (Please circle) ? Yes or No

Please rate child's medical health: Excellent Good Average Poor

Is your child on medication? If yes, what kind(s) and dosage(s):

_____

_____

Does your child have an addiction (Please circle)? Yes No Uncertain

Has your child had any previous physical/sexual/emotional trauma (Please describe)?:

_____

_____

_____

Has your child ever been arrested (Please circle)? Yes or No

Please circle anything your child has experienced in the past 12 months: **Death of parent(s)/ Divorce of parent(s)/Separation of parent(s)/Remarriage of parent(s)/ Death of close family member or friend/Personal injury or illness/ Fired from work/ Change in family member's health/ Pregnancy/ Abuse or Neglect/ New addition to the immediate family/ Change of financial status of parent(s)/ Foreclosure of parent(s) mortgage or loan/ Change in work responsibilities/ Sibling(s) leaving home/ Change in parent(s) work hours/ Jail of family member/ Change in living conditions or residence/ Change in schools/ Change in sleeping habits/ Change in social activities or interests/ Change in eating habits/ Change in homework, grades, or attendance at school/ Other:**

Child Intake Form Continued (to be completed with parent)

What concern has caused you to bring in your child for counseling at this time?

What has been done about your concern up to this present time?

Has anyone in the family experienced similar problems?

What specifically do you expect your counselor to do to help you with your concern?

What is your assessment of your child's personality? Strengths, weaknesses, etc.

Child Intake Form Continued (to be completed with parent)

What is the current family situation?

How do the parents relate to each other?

What is the parents style of discipline?

What are your expectations for your child?

How is your child different from other members of the family?:

How does your child handle stress?:

Did your child meet developmental milestones within normal limits (Please circle): Yes or No

Any other information you think I should know?

Child Intake Form Continued (to be completed with child)

What is your understanding of why you are meeting with me?

What are you good at doing?

What do you like about yourself?

What do other people say that they like about you?

Are there things that you are afraid of?

If you had three wishes what would they be?

If anything in your life could be different, what would you want to change?

What are three things that are important to you?

If you had $1,000 what would you buy with it?