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Child Intake Form

Please fill out this biographical background form as completely as possible for your child. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. Please print or write clearly and bring it with you to the first session.

Identifying Information Date ___________________

Client's Name: ____________________________________ DOB: _________ Age: __________

Person completing the form: __________________________ Relationship: _______________

Address: ____

Home Phone Number: ____________________________ Cell: __________________________

Current School ___________________________________Grade _________________________

Child's Physician __________________________________Date of last Exam: ________________

Medications child is currently taking: ____

Reason you are seeking services for this child? (Please be specific) ________________________

____

____

How long has this been occurring?____

Please list dates and counseling services previously received by the child:

Name	Dates	Reason for services
1.		
2.		
3.		

Please describe the child's strengths, skills and supports: _____________________________

____

____

Family History

Parent Information:	Parent Information:
Name	Name
DOB	DOB
Address	Address
Cell Phone	Cell Phone
Occupation	Occupation
Highest Level of Education	Highest Level of Education

Who has legal guardianship of your child? ____

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? ☐Yes ☐No If yes, please describe: ____

____

Please list all significant relationships in the child's life:

Name	Relationship to Client	Age	Grade/Occupation	Lives with child
1.				☐ Y ☐ N
2.				☐ Y ☐ N
3.				☐ Y ☐ N
4.				☐ Y ☐ N
5.				☐ Y ☐ N

Please include additional significant relationships on the back of this paper.

Has the child experienced any of the following? Please include dates/age if yes.

Y N
☐ ☐ Adoption/foster care
☐ ☐ Parents separated
☐ ☐ Parents divorced
☐ ☐ Parents in new relationship/remarried
☐ ☐ Physical violence at home
☐ ☐ Recent move
☐ ☐ Change in schools
☐ ☐ Physical abuse
☐ ☐ Emotional abuse
☐ ☐ Sexual abuse
☐ ☐ Bullying
☐ ☐ Parent(s) arrested

Y N
☐ ☐ Separation from parent(s)
☐ ☐ Sibling arrested
☐ ☐ Child arrested/Juvenile Hall
☐ ☐ Major illness/accident: Child
☐ ☐ Major illness/accident: Other
☐ ☐ Birth of sibling
☐ ☐ Sibling left home
☐ ☐ Death of sibling/parent
☐ ☐ Death of other relative/friend
☐ ☐ Family Financial Problems

School History

Current School: ______________________________ Grade: ______ Teacher: _________________

What does your child's teacher say about him/her? ____

____

Has your child ever repeated a grade? If so which one(s)? _________________________________

Has your child ever received special education services? __________________________________

Has your child experienced any of the following problems at school?

☐ Fighting	☐ Poor grades	☐ Drug/alcohol
☐ Lack of friends	☐ Poor attendance	☐ Behavior problems
☐ Suspension	☐ Learning disabilities	☐ Incomplete homework
☐ Detention	☐ Gang influence	☐ Other: _______________________

Medical History

What is the name of your child's medical doctor? ____

Address: _______________________________________ Phone: _____________________________

Date of your child's last medical examination: ____

Please list any known allergies: ____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones: ____

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them: ____

Has your child experienced any of the following medical problems?

☐ A serious accident	☐ Hospitalization	☐ Surgery
☐ A head injury	☐ High fever	☐ Convulsions/seizures
☐ Eye/ear problems	☐ Meningitis	☐ Hearing problems
☐ Allergies	☐ Asthma	☐ Loss of consciousness
☐ Chicken Pox	☐ Mumps	☐ Headaches
☐ Bed wetting	☐ Soiling	☐ Diarrhea/Constipation

☐ Other ____

Please list any current medical problems or physical handicaps: ___________________________

____

Please list any medications your child takes on a regular basis: ____________________________

____

Developmental History

Was this child premature or overdue? ____________ Birth weight: ____________________

Were there any difficulties or peculiarities in this child's appearance or behavior at birth or during infancy? If yes, please describe: _____________________________________

____

Were there any problems in feeding this child as an infant? _________________________

How would you describe this child as a baby? (friendly, shy, etc.) _____________________

____

Does this child seem easier, the same or harder to raise than your other children or like age children you know? Please explain: ____

____

Does your child experience any of the following?

☐ Poor coordination	☐Clumsiness	☐ Daredevil behavior
☐ Impulsiveness	☐Unusual fears	☐ Sleep problems
☐ Rocking?	☐Head banging	☐ Appetite/eating problems

Describe your child's sleep patterns and habits?__________________________________

____

Describe your child's eating patterns and habits? _________________________________

____

Please use the other side of the page for any other information you would like me to know about your child and your situation