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PSYCHOTHERAPIST & CREATIVE ARTS THERAPIST
LICENSE NO. 001343-1

CHILD INTAKE

Today's Date: _____

A. General Information
Please provide the following information and answer the questions below. Please note that information you provide here is protected as confidential information.

1. Client Name: _____ Date of Birth: _____
(First, Middle Initial, Last) (mm/dd/yyyy)

Name of parent/guardian: _____
(First, Middle Initial, Last)

Address: _____
(Street/P.O. Box) (Apartment/Suite)

_____
(City) (State) (Zip Code)

Referred by (if any): _____

Name of Primary Care Physician: _____ Phone Number: _____

How many people reside in your household(s) child lives in? _____

Child's Gender:

____ Female Race: _____

____ Male Ethnicity: _____

____ Transgendered

____ Other: _____ Religion/Spirituality: _____

Preferred Pronoun: _____
(she/he/they/etc.)

2. Current Source of Income and Health insurance:

Annual Family Income: _____

3. Children's Names (Child and any siblings/step-siblings)

Children's Names	Child Being Assessed	DOB	Gender	School/Grade

4. Who else lives in the household(s) child resides in?

5. Who are significant people in your child's life?

6. How did the parents' meet? Describe current relationship between child's parents, including any outstanding legal/custody disputes

B. Developmental History

1.Was pregnancy planned or unexpected?

2. Did mother receive prenatal care?

A. any complications with delivery?
B. length of hospital stay:
C. full-term or early/late births:
D. birthweight?
E. AGPAR score (if known)?

3. Did mother/primary caregiver return home with child?

4. What were your children like as infants and toddlers?

5. Sleeping issues (early, middle, terminal insomnia; excessive; impaired, etc):

C. Milestones

Child's Name			
Walking			
Talking			
Toilet Trained			

Since your child was trained have they had any problems with accidents or bedwetting?D. Medical History & Records

1.Immunization:

a. Is your child up-to-date with their immunizations? [ ] Yes [ ] No

2. Medical conditions

a. Asthma
b. Allergies
c. Hospitalizations
d. Medications
e. Other conditions or history we should be aware of?

E. Psychotherapy/Counseling History

1.Have you or your child attended any kind of counseling or psychotherapy in the past?

1.What led you to seek counseling/psychotherapy for yourself or your child?

3. What were your and your child's reactions to counseling/psychotherapy?

F. Presenting Problems

1.Child's Strengths:

2. Behavioral Issues:

3. Emotional Issues:

4. Academic Issues/any special academic needs:

5. Social Issues:

6. Other concerns:

G. Parenting

1.What are your expectations for counseling with your child?

2. How would you describe your relationship with your child?

3. Do you and your children enjoy doing things together? (Like what?)

5. How does/did your partner/ex-partner discipline your children?

6. How does your family show affection towards each other?

7. How does your family show anger?

8. Please describe a day in the life of your child

9. What would you like to change about the way you parent, if in any way?

H. Safety Assessment

1.Has your child been exposed to any kind of violence in the home (physical, verbal, sexual)?

2. Has our child been exposed to any kind of violence outside the home (physical, verbal, sexual)?

3. Have your children been exposed to drugs or alcohol at home or outside the home?

Name of Person filling out this Form: _____

Relationship to Child: _____