anathallo COUNSELING

# Child Intake Form

1. Child's Name: _____ Sex: _____ Age: _____ DOB: _____

2. Natural Child ☐ Yes ☐ No

If adopted, at what age? _____ Foster since (year): _____

3. Parent's Names (include step-parents, foster parents, inc.):

4. Comments about custody and visitation (if applicable):

5. Primary reason you are concerned about your child?

## Symptoms/Problem Checklist

Check any symptom that is a concern.

a.

- ☐ Sleep problems
- ☐ Lack of interest in activities
- ☐ Unassertive
- ☐ Fatigue / low energy
- ☐ Concentration problems
- ☐ Appetite / weight changes
- ☐ Withdrawal
- ☐ Morbid thoughts
- ☐ Suicidal thoughts or threats
- ☐ Suicidal plans / attempts
- ☐ Mood swings
- ☐ Depression
- ☐ Changed level of activity
- ☐ Cries easily

b.

- [ ] Forgetful / memory problems
- [ ] Short attention span
- [ ] Aggressive behavior
- [ ] Can't sit still
- [ ] Not interested in peers
- [ ] Picked on / bullied by peers
- [ ] Talks excessively / interrupts
- [ ] Easily distracted
- [ ] Irritable
- [ ] Impulsive
- [ ] Difficulty following rules
- [ ] Problem completing schoolwork

c.

- [ ] Excessive worry / fearfulness
- [ ] Anxiety or panic attacks
- [ ] Social fears, shyness
- [ ] Separation problems
- [ ] Bedwetting / soiling
- [ ] Headaches, stomachaches
- [ ] Odd beliefs / fantasizing
- [ ] Nightmares
- [ ] Frequent tantrums
- [ ] Resistive to change
- [ ] School refusal
- [ ] Perfectionism
- [ ] Odd hand / motor movements
- [ ] Hallucinations

d.

- [ ] Lying
- [ ] Trouble with the law
- [ ] Running away
- [ ] Truancy, skipping school
- [ ] Hurting others sexually
- [ ] Alcohol / drug use
- [ ] Argumentative / defiant
- [ ] Swears
- [ ] Blames others for mistakes
- [ ] Stealing
- [ ] Being destructive
- [ ] Fire setting
- [ ] Hurting others / fighting
- [ ] Acts as if has no fear
- [ ] Short tempered
- [ ] Easily annoyed / annoys others
- [ ] Discipline problem
- [ ] Angry and resentful

For any symptom that you have checked, please list the symptom and number of months or years this has been a problem.

Brothers and Sisters

| First Name - Last Name | Sex | Age | Relationship to child (full, step, half, foster) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

## School History

1. Present School: _____Grade: _____ Teacher: _____
2. Has child ever repeated any grade? _____
3. Is child in special education services? ☐ No ☐ Yes, what kind?
4. Please describe academic or other problems your child has had in school:

## Child's Development and Medical History

1. <u>Pregnancy</u>

   Mother used during pregnancy: ☐ alcohol ☐ drugs ☐ cigarettes

   Delivery: ☐ Normal ☐ Breech ☐ Cesarean ☐ Transectional

   ☐ Full-term ☐ Premature If premature, number of weeks _____

   Birth Weight: _____

Problems at birth (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc.):

2. Developmental History

**State approximate age when child did the following:**

Walked alone ____ Said first word _____ Used 2-word phrases _____

Understood and followed simple directions _____

Reasonably well toilet-trained _____

Did child cry excessively? _____ Rarely cried _____

3. Health History of Child

**In the first two years, did your child experience**:

☐ Out of home care ☐ Disruption in bonding ☐ Separation from mother

☐ Abuse ☐ Neglect ☐ Depression of mother

☐ Chronic Illness ☐ Parental Stress ☐ Chronic pain

Child's Doctor: _____

Date of last physical exam: _____

Vision problems? ☐ Yes ☐ No Hearing problems? ☐ Yes ☐ No

Dental problems? ☐ Yes ☐ No

Any head injuries or loss of consciousness? ☐ Yes ☐ No

Child's history of serious illness, injury, handicaps, or hospitalization ☐ No ☐ Yes

Describe and give dates:

Is your child currently taking any medications? ☐ No ☐ Yes

Name medications: _____

List any medicines previously used for emotional problems:

Were they helpful?

Allergies to drugs or medicines? ☐ No ☐ Yes

(list)

Allergies to any foods? ☐ No ☐ Yes

(list)

Are there any foods that you limit or do not give this child? ☐ No ☐ Yes

(list)

Allergies to environmental conditions? ☐ No ☐ Yes

(list)

Does anyone in the household smoke? ☐ No ☐ Yes

About how many hours does this child watch TV, videos, etc. per day _____

Are you afraid someone you know may injure/harm this child? ☐ No ☐ Yes

National Domestic Violence Hotline 1-800-799-7233

Does this child have a Health Care Directive? ☐ No ☐ Yes

If yes, please list where (which clinic) it is on file _____

Any previous psychological or psychiatric treatment? ☐ No ☐ Yes

Whom/where _____When_____

Any previous testing (school/psychological)? ☐ No ☐ Yes

Whom/where _____When_____

Do you think your child's use of chemicals is a problem? ☐ No ☐ Yes

Type: ☐ Alcohol ☐ Marijuana Other drugs _____

Comments: _____

## Family History

Chemical use (now & past): ☐ No ☐ Yes Which parent: _____

Type: ☐ Alcohol ☐ Marijuana ☐ Other drugs _____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

Has child witnessed domestic violence? ☐ No ☐ Yes Specify:

How is your child disciplined? Please list each method and frequency of use:

## Life Stressors/Trauma History

1. Has your child been verbally abused? ☐ No ☐ Yes Suspected. Specify:

2. Has your child been physically abused? ☐ No ☐ Yes Suspected. Specify:

3. Has your child been sexually abused? ☐ No ☐ Yes Suspected. Specify:

4. Other stressors or traumas?

5. What are your child's strengths?

6. Any additional comments or information that would be helpful to us?

Signature of person completing form / relationship to client:

_____ Date: _____

Name Relationship