Client Information: Child Intake

The following information will be kept strictly confidential.

Child's Name:	**Today's Date:**
Date of Birth:	**Insured Name:**
Age:	**Insured SSN:**
Gender:	**Employer of Insured:**
SSN:	**Relationship to Insured:**
Home Address (Street, City, State, Zip):	**Mailing Address** (if different):
Daytime Phone:	**Home Phone:**
Cell Phone:	**Email Address:**

Ethnicity (This data is required for legal purposes): ☐ African-American/Black ☐ Asian ☐ Hispanic ☐ Caucasian/White ☐ Hawaiian/Pacific Islander ☐ Native American ☐ Other _____

Who has ***legal guardianship*** of the child? Include **all** name(s) and Relationship(s):

_____

Who has ***legal rights*** to the child's medical records? Include **all** name(s) and Relationship(s):

_____

Birth Mother's Data: Name:_____ Age:_____
Current status: ☐Single ☐ Cohabitating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Not applicable/no information Is birth mother in meaningful contact with child? ☐Yes ☐ No

Birth Father's Data: Name:_____ Age:_____
Current status: ☐ Single ☐ Cohabitating ☐ Married ☐ Separated ☐Divorced ☐ Widowed
☐ Not applicable/no information Is birth father in meaningful contact with child? ☐Yes ☐No

Emergency Contact Person(s) and phone numbers: _____

Primary Care Provider: _____
Name Practice Address
When did the child last see his/her Primary Care Provider? _____

Who referred the child to Albemarle Counseling Group? _____

Why has the child been referred to Albemarle Counseling Group? _____
_____

What happened to make you seek treatment for the child *now*? _____
_____

*Please list **ALL PEOPLE** typically living in home with the child.* Use other pages as necessary:

Name	Age	Gender	Relationship to child (for example mother, father, stepparent, brother, sister, half-sibling, step sibling, cousin, grandparent, etc.)	Occupation or grade

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Emotional/Behavioral Problems: Please check any significant problems that the child has had.

	Now	Past		Now	Past
Problems sleeping	☐	☐	Decreased appetite/weight loss	☐	☐
Problems concentrating	☐	☐	Increased appetite/weight gain	☐	☐
Crying spells (sadness)	☐	☐	Feeling hopeless/helpless	☐	☐
Temper tantrums	☐	☐	Anxiety/Worry	☐	☐
Depression/Sadness	☐	☐	Thoughts of hurting others	☐	☐
Thoughts of suicide	☐	☐	Antisocial or criminal behavior	☐	☐
Problems getting along with peers	☐	☐	Problems with drugs/alcohol	☐	☐
Problems getting along with adults	☐	☐	Problems with the past	☐	☐
Disturbing thoughts	☐	☐	ADHD	☐	☐
Obsessions/Compulsions	☐	☐	Inability to change routines	☐	☐
Intentional Self-Injury	☐	☐	Repetitive movements	☐	☐

Please list any other emotional/behavioral problems that the child has demonstrated:

_____

_____

Medical and Psychotherapy:

Does the child suffer from any ***current significant medical*** conditions? ☐Yes ☐No If yes, what?

_____

Please list any ***known drug allergies***: _____

*Please list **any significant** medical treatments that the child has undergone (Include surgeries, medical therapies, and hospitalizations):*

Type of Treatment	Treatment for what Disorder	Date of Treatment	Did/does it help?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

*Please list any **psychotherapeutic or behavioral health treatments** the child has undergone (Include **outpatient counseling,** psychiatric hospitalizations, residential treatment, and medication management.):*

Type of Treatment (i.e. inpatient, outpatient, med management)	Treatment for What Disorder	Provider	Date of Treatment	Did/does it help?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

*Please list **all current medications***

Name of Medication	Dosage	Prescribed for What Disorder	Date Treatment Started	Prescribing Physician	Did/does it help?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Family History:

Who has primarily raised the child? Name(s) and Relationship(s): _____

_____

Mother's or Female Guardian's (Please indicate which) Name: _____

Age (if alive): _____ If deceased, how old was child at time of death? _____

What type of work does/did she do?_____

Father's or Male Guardian's (Please indicate which) Name: _____

Age (if alive): _____ If deceased, how old was child at time of death? _____

What type of work does/did he do? _____

Were the birth parents married? ☐Yes ☐No If yes, did the birth parents stay married? ☐Yes ☐No

If still married, for how long have parents or guardians been married?_____

If they divorced, how old was the child at the time of the divorce? _____

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Did either of the child's ***parents remarry and/or have a significant relationship*** with someone who provided parent-like care? ☐Yes ☐No If yes, please list ***names of step and surrogate parent(s), and dates of when the parenting occurred.*** Also indicate if the relationship was positive for the child:

_____

_____

_____

Other Siblings*: Please list all siblings or sibling-like relationships of importance to the child* ***WHO ARE NOT*** *currently living in the home. Include half, surrogate, & step siblings.*

Sibling's name (include half, step, and surrogate, etc. siblings)	Gender	Age	Relationship to child (Brother, sister, half, step)	Living where or with whom?	Degree/quality of contact with child?

Have any members of the child's family suffered from mental, emotional, or nervous problems?
☐Yes ☐No If yes, please describe who and type of problem: _____

_____

Have any members of the child's family suffered from problems with drugs or alcohol abuse?
☐Yes ☐No If yes, please describe who and type of problem: _____

_____

Early Childhood History:

As far as you know, did the child's mother have any problems with the gestation and/or delivery of the child? ☐Yes ☐No If yes, what? _____

Was child premature? ☐Yes ☐No If yes, how many weeks of gestation? _____ Birth weight:_____

As far as you know, was the child considered to have been healthy and well at birth? ☐Yes ☐No If no, what were the medical issues? _____

Did the child show developmental delays in any of the following areas?:

Milestone	Problem? If yes, age attained	Milestone	Problem? If yes, age attained?	Milestone	Problem? If yes, age attained?
Smiling	☐Yes ☐No Age:	Walking	☐Yes ☐No Age:	Toilet Training	☐Yes ☐No Age:
Sitting up	☐Yes ☐No Age:	Speaking in single words	☐Yes ☐No Age:	Bed-wetting	☐Yes ☐No Age:
Crawling	☐Yes ☐No Age:	Speaking in 3-word sentences	☐Yes ☐No Age:		

Loss/Abuse/Neglect/Trauma:

Has the child experienced any major illness, losses, or separations?
☐ Yes ☐No If yes, please describe. _____

_____

Has the child ever been physically abused, verbally or emotionally abused, molested, or neglected?
☐Yes ☐No If yes, please describe: _____

Has the child ever suffered any trauma? ☐Yes ☐No If yes, please describe:_____

How many times has the child moved (from one home to another)? ____ At what ages? _____

Has the child ever been placed outside of his usual home? ☐Yes ☐No If yes, please describe. Include number and kinds of placements and how long each placement lasted: _____

_____

Social/Interpersonal/Current Life Situation:

Does the child seem to "fit in"? ☐Yes ☐No Comments: _____

Does the child seem to have friends? ☐Yes ☐No If no, why do you think he/she has problems with making friends? _____

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Does the child typically keep friends? ☐Yes ☐No If no, why do you think he/she has problems with keeping friends? _____
Does the child seem to make friends of his/her own age? ☐Yes ☐No If no, are the friends younger or older than the child? _____
Do you approve of your child's friends? ☐Yes ☐No If no, why? _____
Has the child ever been significantly bullied at any time? ☐Yes ☐No Please describe: _____
Is your child a bully? ☐Yes ☐No Please describe: _____
Has child begun to date? ☐Yes ☐No If yes, age child started dating: _____
To your knowledge, is child sexually active? ☐Yes ☐No
What, if any, extracurricular activities is your child involved in on a regular basis? _____
_____

Substance Abuse/Legal Issues:
What is the child's caffeine intake (include sodas)? _____ cups per day.
Has there been any problems with drinking alcohol with the child?.....☐ Yes ☐No
If yes, please describe: _____
Does the child smoke cigarettes? .....☐ Yes ☐No If yes, current habit: _____
Has there been any problems with drugs/substance abuse with the child?.....☐ Yes ☐No
If yes, please describe: _____
Has the child ever been arrested for and/or convicted of a crime? .....☐ Yes ☐No
If yes, please describe: _____
Has the child ever been placed on juvenile probation? .....☐ Yes ☐No
If yes, please describe: _____
Has the child ever been sent to juvenile detention? .....☐Yes ☐No
If yes, please describe: _____

School and Academics:
What grade is the child in school? (If summertime intake, grade next year.) _____
Current Name and county of school: _____
Is this school public, private or home school? _____
What academic marks (grades) are typical for the child? _____
Is the child achieving at grade level? ☐Yes (regular curriculum) ☐Yes (modified curriculum) ☐No
Is the child currently on an Individual Education Plan or Section 504 Plan? ☐Yes ☐No If yes, which plan (IEP or 504) and what is his/her qualifying condition? _____
Has the child ever been retained or failed a grade? ☐Yes ☐No If yes, what grade(s)? _____
Has the child ever been enrolled as an Exceptional Children's Program Student (Special Education)?
☐Yes ☐No If yes, what is his/her qualifying condition? _____
If enrolled in public school, what is the child's current classroom setting? (Please check all that apply)

- ☐ Regular full day classroom setting
- ☐ Combination of regular and resource room placement
- ☐ Enrollment at alternative school
- ☐ Mainstream with inclusion help
- ☐ Full day exceptional children's classroom
- ☐ Home bound instruction

Since starting school, how many schools has the child attended (include homeschools)?_____
Does the child have any conduct or behavioral problems at school? ☐Yes ☐No
If yes, please describe: _____

Social and Emotional Support/Goals:
Who is on the child's "side"? _____
Is the child involved in organized religion? ☐Yes ☐No If yes, faith: _____
What changes do you hope to achieve by bringing the child to see the therapist?
_____
_____
What else would you like the counselor to know about your child? _____
_____
_____

Signature of person completing form: _____