# Therapeutic Family Center

## CHILD INTAKE FORM

**GENERAL INFORMATION**

*Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.*

Child's Name:_____ Today's Date:_____

_____

Child's age: _____ Date of Birth (DOB):_____

Address:_____

_____

_____

_____

Parent's Name: _____ Parent's Name: _____

_____

Home phone:_____ May I leave a message? Yes

No

Cell phone:_____May I leave a message? Yes

No

Work phone:_____ May I leave a message? Yes

No

Email: _____ May I email you? Yes

No

(For appointment scheduling purposes only, as email not considered a confidential medium of communication).

**INSURANCE INFORMATION**

Insurance Company:_____ Name of Insured:_____

_____

Insured's Date of Birth: _____

Insured's Employer:_____ Policy Name: _____

Insured's Member ID #:_____ Insured's Group #:_____

Insured's Relationship to the Client:_____ Authorization # (if needed):_____

Address for Submitting Claims: _____

Who referred your child to my private practice? Please provide agency, Person's name /professional's name & tel #:

May I contact the agency/person to thank them for referring you? Yes No
Please initial:_____

What is the primary reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems):_____

What are your expectations regarding your child's therapy?_____

**HEALTH & MENTAL HEALTH INFORMATION**

Does your child presently have any medical problems? _____

Has your child ever been treated for any of the following? If so please circle and describe: Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions:

_____

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

Please list your child's current prescription medications with dosage (psychiatric and general health):

Please list any previous psychiatric medications (with dosage and dates):

Do you suspect your know your child drinks alcohol or uses recreational drugs? If so, what kind & how often?

Do you or anyone close to your child consider his/her use to be a problem?

Yes No

Who is your child's primary care physician?

Who is your child's psychiatrist (if applicable)?

When was your child's last complete physical exam (mo/year)? _____

_____

How many times a week does your child exercise? _____What type & how many minutes? _____

_____

What types of food does he/she often eat? _____

_____

_____

**YOUR CHILD'S FAMILY**

| | **BIOLOGICAL MOTHER** | **BIOLOGICAL FATHER** |
|---|---|---|
| **Current age, or If deceased date, age, & cause of death** | | |
| **Country of Origin** | | |
| **Occupation** | | |
| **Religious/Spiritual Affiliation (if any)** | | |
| **Highest grade completed** | | |
| **Any history of the following (please circle)** | Learning Problems<br>Speech Problems<br>Medical Problems<br>Emotional Problems<br>Alcohol or Substance Abuse | Learning Problems<br>Speech Problems<br>Medical Problems<br>Emotional Problems<br>Alcohol or Substance Abuse |
| **Describe each parent's relationship with the child** Give some examples of things | | |

| | | |
|---|---|---|
| that you do together & feelings you have | | |

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

_____ -____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? _____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:_____

_____

_____

**Siblings**

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

| First name | Biological, Adopted or Step | Present Age | School grade? | Male/ Female | Lives with you? (Yes/No) | Any medical, social or academic problems (please list for each)? |
|---|---|---|---|---|---|---|
| | | | | | | |
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**FAMILY MENTAL HEALTH HISTORY**

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

| | Please circle | List Family Member(s) |
|---|---|---|
| Anxiety (general) | Yes No | |
| Obsessive Compulsive Behavior | Yes No | |
| Depression | Yes No | |
| Suicide Attempts | Yes No | |
| Bipolar/Manic Depressive | Yes No | |
| Alcoholism | Yes No | |
| Substance Abuse | Yes No | |
| Domestic Violence | Yes No | |
| Eating Disorders | Yes No | |
| Obesity | Yes No | |
| Schizophrenia | Yes No | |
| Counseling or Psychotherapy | Yes No | |
| Psychiatric Hospitalizations | Yes No | |

## YOUR CHILD'S DEVELOPMENTAL HISTORY

### Pregnancy and Birth

Where there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe:

Medications used during pregnancy? Please list: _____

_____

Smoking? Yes No How much? _____

_____

Alcohol intake? Yes No How much? _____

_____

Drug intake? Yes No How much? _____

_____

Length of pregnancy?___Weeks Age of mother at birth: _____Birth weight: _

_____

Were there any complications during delivery? If so, please describe: _____

_____

_____

_____

Length of stay in the hospital? Mother: _____(days) Child: _____(days)

**Developmental Milestones and Early Development**

At what age did your child do the following (indicate approximate month or year of age for each):

Turn over _____ Crawl_____ Stand Alone_____ Walk Alone _____

First Words _____ First Phrases_____

Toilet trained? Yes No If yes, days?_____Nights? _____

Has your child wet or soiled himself after being trained? Yes No If yes, until what age? _____

Enjoyed cuddling? Yes No

Fussy, Irritable? Yes No

More active than other babies? Yes No

If your child has siblings, was development different in any way? Explain:_____

_____

_____

_____

_____

_____

**YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING**

**School/Academics**

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No

If so, which? _____

School name: _____Public or Private (circle one)?

Street Address: _____

_____

School District/County? _____ Phone: ___(____)_____

_____

What preschool experience did your child have? _____

_____

Where any problems detected in your child's kindergarten screening? Yes No If so, please explain:

Is your child in a regular classroom? Yes No Does your child have an IEP? Yes No

Has your child ever received tutoring? Yes No If so, please explain:

What are your child's typical grades?

What are your child's strongest and weakest points academically?

Are you satisfied with your child's educational program? Yes No Please explain:

**Home/Family Life**

What are 5 things that you enjoy most about your child?

What are some activities you engage in as a family?

Does your child participate in any religious or faith based group?

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques?

What are your strengths personally and as a parent?

What are some of your areas of needed growth?

What are your child's strengths (things he/she is good at)?

What are your child's areas of needed growth?

**Social and Community Engagement**

What are your child's favorite activities or hobbies?

In what extracurricular/community activities is he/she involved?

How does your child get along with other children?

Who are some of your child's closest friends (first name)

**Your Child's Symptoms or Problems**

How much are each of the following areas currently a problem for your child?

| | **Not at all** | **A little** | **Somewhat** | **Considerably** | **Terribly** |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| Anxiety | 1 | 2 | 3 | 4 | 5 |
| Physical Problems | 1 | 2 | 3 | 4 | 5 |
| Sleep Problems | 1 | 2 | 3 | 4 | 5 |
| Depression | 1 | 2 | 3 | 4 | 5 |
| Alcohol or Substance Abuse | 1 | 2 | 3 | 4 | 5 |
| Parent-Child Conflicts | 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| Sibling Conflicts | 1 | 2 | 3 | 4 | 5 |
| Social Relationships | 1 | 2 | 3 | 4 | 5 |
| School Problems | 1 | 2 | 3 | 4 | 5 |
| Sexual Problems | 1 | 2 | 3 | 4 | 5 |
| Spiritual/religious | 1 | 2 | 3 | 4 | 5 |
| Legal problems | 1 | 2 | 3 | 4 | 5 |
| Eating Disorder | 1 | 2 | 3 | 4 | 5 |
| Abuse (physical, emotional, sexual) | 1 | 2 | 3 | 4 | 5 |

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? Yes No

(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No

If yes, please describe:_____

_____

_____

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: _____

_____

_____

_____

_____

_____