PSYCHOTHERAPEUTIC RESOURCES
CHILD'S CLINICAL INTAKE

(THIS FORM WILL NEED TO BE COMPLETED AND RETURNED AT THE TIME OF YOUR FIRST APPOINTMENT)
In order for us to be able to fully evaluate your child, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to; do the best you can. Thank you.

PATIENT IDENTIFICATION
Child's Name____ Today's date_________________
Birth Date_____________________ Age____________ Sex______________ Race_____________ Grade____________
School____ Religion_________________________________
Address____
City____ State___________________ Zip____________________
Home Phone#____________________________ Parent's Work#__________________________ (specify mom or dad)
Who is the child currently living with? ____
Legal Guardian: ____
Name of person filling out this form? ____

REFERAL SOURCE
Referral Source ____ Phone# ___________________________

In an effort to coordinate care, we would like to obtain/give information from previous providers and/or your referral source. With your written authorization, we will be informing your physician (by letter) of your diagnosis and care here, communicating (as necessary) with your referring agent and requesting past mental health records.
Please check: **YES**, and provide us with the names and addresses needed to prepare the authorization form(s) or check **No** if not necessary at this time.

Primary Care: ____ **Yes ____ No____***

Referral Source: ____ **Yes ____ No____***

Past Mental Health: ____ **Yes____ No____***

REASONS FOR THERAPY
Primary reason for seeking therapy: ____
____
How long have these problems been developing? ____
____
Has therapy been discussed prior to this appointment? Circle: Yes No
If yes, what was the child's reaction? ____

GOALS
What are the goals for your child's therapy? ____
____
____
____

OTHER SERVICES

Please list all services that have been or currently are being used to address current problems (include probation; social services; prior therapy; or, any other services)

Agency	Date
______________________________	____________
______________________________	____________
______________________________	____________

Is the child receiving any special services in school; i.e. IEP, Special Ed, EBD (EMOTIONAL BEHAVIORAL DISORDER)?

____

Please describe child's experience with the above services. Was he/she helped? How did he/she feel about the above services and/or prior therapy? ____

____

History of Abuse (check all that apply)

- ⬡ Physical Abuse: by whom? ______________________ What ages? ____________
- ⬡ Sexual Abuse: by whom? ______________________ What ages? ____________
- ⬡ Verbal Abuse: by whom? ______________________ What ages? ____________

MEDICAL HISTORY

Current medical problems/medications: ______________________________________

____

Past medical problems/medications: ____

____

Other doctors/clinics seen regularly: _______________________________________

____

Any history of head trauma? (Describe) _____________________________________

Ever have any seizures or seizure like activity? _______________________________

Prior hospitalizations (place, cause, date, outcome)? ___________________________

Prior abnormal lab tests, X-rays, EGG, etc.? _________________________________

Allergies/drug intolerance? (Describe): _____________________________________

Present Height: ________________ Present Weight: ________________

FAMILY IDENTIFACTION AND HISTORY

Please name each person (including parents, stepparents, adoptive parents, or full, half or step siblings) **CURRENTLY** living in the same household as this child:

Person	Age	Relationship to client
Person #1	Age	Relationship to client
Person #2	Age	Relationship to client
Person #3	Age	Relationship to client
Person #4	Age	Relationship to client
Person #5	Age	Relationship to client
Person #6	Age	Relationship to client
Person #7	Age	Relationship to client

Has this child experience the loss by death of any individual or pet significant in his/her life? If yes please describe, who, when and how? ____
____
____

Has this child experience the divorce or breakup of parents' relationship? If yes, please describe the child's reaction to the breakup. ____
____

Is this child adopted? _____________________________ If so, at what age? ____________________________________

Describe any difficulties, if any, that are related to being adopted. ____
____

Describe any relationship difficulties this child may have with any member of the household. _______________________
____

STRESSORS

Have any of the following caused stress for this child?

<u>Event (circle):</u>	**<u>Give year and description:</u>**
Moved	____
Changed schools	____
Serious illness or injury in family	____
Death	____
Change in family financial status	____
Job change in family	____
Parent starting work outside of home	____
Divorce or separation	____
Sibling leave home	____
Foster care replacement	____
Family legal problems	____
Traumatic event(s)	____
Parental conflict/family violence	____

Biological Mother's History: Name ____ Age _______________

Outside work ____ School: Highest grade completed: __________________

Learning problems (specify): _____________________________ Behavioral problems (specify): ______________________

Marriages ____

Medical problems ____

Childhood atmosphere (family position, abuse, illness, etc.)____
____

Have you ever experienced: (circle if yes)

Sexual Abuse Physical Abuse Emotional/Harassment

Has mother ever sought mental health treatment? Yes ________ No_________ if yes, for what purpose? ____________
____

Mother's alcohol/drug use history? ____

Have any of the mother's blood relatives ever had any learning problems or mental health problems including such things as alcohol/drug use, depression, anxiety, suicide attempts, and/or mental health hospitalizations? Specify. ______
____
____

Biological Father's History: Name ____ Age ________________
Outside work ____ School: Highest grade completed: __________________
Learning problems (specify): ____________________________ Behavioral problems (specify): ______________________
Marriages ____
Medical problems ____
Childhood atmosphere (family position, abuse, illness, etc.)____
____
Have you ever experienced: (circle if yes)
Sexual Abuse Physical Abuse Emotional/Harassment
Has father ever sought mental health treatment? Yes ________ No_________ if yes, for what purpose? ____________
____
Father's alcohol/drug use history? ____
Have any of the father's blood relatives ever had any learning problems or mental health problems including such things as alcohol/drug use, depression, anxiety, suicide attempts, and/or mental health hospitalizations? Specify. ___________
____
____

Step or Adoptive Mother's/Father's History: Name ___________________________________ Age _____________
Outside work ____ School: Highest grade completed: __________________
Learning problems (specify): ____________________________ Behavioral problems (specify): ______________________
Marriages ____
Medical problems ____
Childhood atmosphere (family position, abuse, illness, etc.)____
____
Have you ever experienced: (circle if yes)
Sexual Abuse Physical Abuse Emotional/Harassment
Has step or adoptive mother/father ever sought mental health treatment? Yes _____ No_____ if yes, for what purpose?
____
Step mother/father's alcohol/drug use history? ____

CHILD'S DEVELOPMENTAL HISTORY

Prenatal events (check one):
⬡ Planned Pregnancy ⬡ Unplanned pregnancy
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc.) ___
____
____

BIRTH AND POSTNATAL PERIOD

Birth weight: ______________________ Length: ______________________ Labor duration: _______________________
Delivery (check all that apply):
⬡ Vaginal ⬡ C-Section ⬡ Full-Term ⬡ Premature
Any other complications:____

Mother's health after delivery: ⬡ Post-delivery blues? IF yes, how long? _______________________________________

Primary caretaker for child: First year____
Thereafter ____

Feeding history (check all that apply):

⬡ Breast ⬡ Bottle Age Weaned: ____

Food allergies: ____

Eating problems: ____

Sleep behavior:

⬡ Sleep walking ⬡ nightmares ⬡ recurrent dreams

⬡ Current problems getting up ⬡ current problems going to bed

Separations from mother and father: Why? ____

Age: _________________ How long? ____

Motor development: (Please write in age, parentheses are approximately normal limits)

Rolls over (3-5months) _________________________ Sit without support (5-7 months) __________________________

Crawls (5-8 months) __________________________ Walks well (11-16 months) _________________________

Runs well (2 years) __________________________ Rides tricycle (3 years) ____________________________

Throws ball overhand __________________________ Fine and gross motor coordination________________________

List any occupational therapy services: ____

____

Language Development: (Please write in age, parentheses are approximately normal limits)

Several words besides dada, mama (1 year) ____

Names several objects ex: ball, cup (15 months) ____

3 words together – subject, verb, object (24 months) ____

Vocabulary __________________________________ Articulation____

Comprehension ____

List any current problems: ____

List any speech or language services: ____

Early social development: (Please write in age, parentheses are approximately normal limits)

Smile (2 months) _____________________ Shy with strangers (6-10 months) _______________________________

Separates from mother easily (2-3 years):____

Cooperative play with others (4years): ____

Early peer interactions: ____

Special interests: ____

Relationships to family members: ____

Toilet Training:

Age reached bowel control: day __________ night __________

Age reached bladder control: day __________ night __________

Current function: ____

Sexual Development:

Has this child sought any sexual information from parents? ⬡ Yes ⬡ No

If yes, please describe nature of questions and manner they were handled?______________________________________

____

Has this child ever behaved or spoken in a way that was not sexually appropriate for a person his/her age? ⬡ Yes ⬡ No

If yes, please describe: ____

Nature of comment or behavior: ____

Age of child at this time: ____________________________ Who noticed or heard? ______________________________

Any current concerns about your child's sexual behavior? Check one. ⬡ Yes ⬡ No

If yes, please describe: ____

Early behavioral/discipline problems (prior to age 5):

Check All That Apply:

⬡ Disobeys ⬡ Property destruction ⬡ stealing

⬡ Rule breaking ⬡ Fire Setting ⬡ Harming Animals

⬡ Physical harm to others ⬡ Harm to self ⬡ Lying

Methods of discipline:

Please describe: ____

How frequent used or needed: ____

Early emotional development (prior to age 5):

⬡ Irritable ⬡ Happy ⬡ Cries Excessively

⬡ Easily Calmed ⬡ Content ⬡ Defiant

Nervous habits: ____

Fears/phobias:____

Special objects (blanket, dolls, etc.): ____

Ability to express feelings: ____

School History

Number of schools attended: ________ Grades repeated: ________________ Average Grades: ____________________

Homework problems: _____________________ Special learning disabilities: ___________________________________

Special Services: ____

Strengths/Activities: ____

Motivation: ____

What have teachers said about child/teen ____

Overall strengths of child – as viewed by parents: ____

____

____

____

Overall strengths – as viewed by child/teen: ____

____

____

____

Other Comments:____

____

____

____

____

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