Psychotherapeutic Resources
YOUR CARING RESOURCE

CHILD 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 Today's date:_____

Child's Name: _____ Date of Birth: _____ Age: _____
Race: _____ Preferred Pronoun: _____ Sex:_____
Grade: _____ School: _____
Address: _____
Cell Phone:_____ Work Phone: _____
Who is the child currently living with?_____
Legal Guardian: _____
Name of person filling out this form?_____

REFERRAL SOURCE

In an effort to coordinate care, we would like to obtain 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)

Agency	Date
Agency	Date
Agency	Date

Is the child receiving any special services in school; i.e. IEP, Special Education, EBD (Emotional Behavior 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):

FAMILY IDENTIFICATION 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 #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 experienced 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?

Event (circle):	**Give year and description:**
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 leaving home	_____
Foster care placement	_____
Family legal problems	_____
Traumatic event(s)	_____
Parental conflict/family violence	_____

Biological Mother's History:

Name_____ Age _____

Job Title: _____ 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 _____
Job Title: _____ 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 _____
Job Title: _____ 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

Please explain any concerns with Motor Development, Language Development, Social Development, Sexual Development or Behavioral/Discipline Problems:

_____
_____
_____

School History

Number of schools attended:_____ 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:

_____

_____

_____

_____

_____