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CHILD THERAPY INTAKE

Identifying Information:

NAME: _____ **DOB:** _____

AGE: _____ **Today's Date:** _____

RACE: _____ **GENDER:** **M / F**

RELIGION/CULTURAL:_____

PARENT INFORMATION (List parents / legal guardians:

Name:	Name:
Relation (Mother/Father:)	Relation (Mother/Father)
Address:	Address:
County:	County:
Phone - home:	Phone Home:
Phone - cell	Phone - cell:
Phone - work:	Phone - work:
Type of work:	Type of work:

Who recommended you here/REFERRAL SOURCE:

Who is with you today?

What is the main reason you are coming in today?

Has your child had any recent evaluations? Yes / No If so what and from whom? (please describe)

Does your child already have a diagnosis? Yes / No If yes, what?

Do you have any questions about the diagnosis? (previous/current/second opinion)

What are your child's strengths?

Does your child exhibit any High Risk Behaviors? Yes / No If yes, please describe:

_____

_____

D. Who is in living in the home?

Name:	Age/grade:	Relation:

Describe any medical problems(chronic illnesses, hospitalization, new diagnosis):

List any medications your child/teen is presently receiving (name of drug(s) and dosage/ times when given):

Please indicate any difficulties your child/teen has had with the following:

Toileting ____ In the past ____ Currently ____ Never
Eating ____ In the past ____ Currently ____ Never
Sleeping ____ In the past ____ Currently ____ Never

Community:
Describe CURRENT community activities (ex. Band, sports, church, etc) Does your child have any problems in this area?

Peer Relationships:
Describe child's CURRENT friends or other important relationships? Does your child have any problems interacting with others?

Drug and Alcohol:
Any CURRENT concerns Yes /No If yes, please describe:

Trauma History: Has your child experienced any traumas that are effecting their mood/behavior? Yes /No If yes, describe:

Legal: Has your child had any legal involvement? (Parents divorced/separated, CYF involvement, involved with the juvenile system, out of home placement of any kind, etc.)
If yes , describe:

Education:
Current school:

Grade:

School address:

School district:

Name of classroom teacher:

Telephone number of school:

Attended pre-school? _____ Yes _____ No
Attended kindergarten? _____ Yes _____ No
In special classes? _____ Yes _____ No
Type of classes? _____ When? _____
Repeated grade(s)? _____ Yes _____ No
If yes, when: _____

Has your child had any psychological testing at school? _____ Yes _____ No
(If yes, please attach a copy of the report or have a copy sent to us.)

Does your child have any behavior or learning problems at school? _____ Yes _____ No
If yes, please describe:

Has your child had any suspensions/detentions in the past year? _____ Yes _____ No
If yes, please describe:

Have you or your child been involved in any type of counseling or mental health services previously? Yes /No If yes , describe:

If yes, were services helpful – if so how? If not – how?

What would you like to see happen as a result of therapy for your child?

Is it ok to email you?_____ (initial if yes)

Email :_____ for (mom/dad)_____
Circle or list

Email :_____ for (mom/dad)_____
Circle or list

Please list or describe below anything else you feel is important for me to know.

Edit 11/2011