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Confidential CHILD Individual Intake Form

Contact Information

Name: _____ Date: _____

Sex: **0** Male **0** Female Height: _____ Weight: _____

SS#: _____ Age: _____ DOB: _____

Address: _____
Street Address City State Zip

Phone: _____
Home Business Cell

Emergency Contact Information

Emergency Contact Person: _____
Name Relationship to you

Emergency Contact's Phone: _____
Home Business Cell

Employment Information

Employer: _____ Occupation/Title:_____

Employer Information: _____
Address Phone

Hours per week: _____ Years at job: _____ Highest level of education completed: _____

Education ( ) Some High School ( )Some College ( ) Graduate School
( ) High School Graduate/GED ( ) College Graduate ( ) Degrees Held _____

Cultural/Religious Information

Race: **0** Caucasian **0** African-American **0** Hispanic **0** Native American **0** Asian **0** Other _____

Cultural heritage (i.e., Italian, Scottish, Argentinean): _____
Do you regularly attend a church, synagogue or other religious institution? **0** Yes **0** No Member? **0** Yes **0** No

Name of church/institution: _____

Name of pastor: _____

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:
What does your child do that you like? What does he/she do that other people like?

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Family History:
The name of the child's biological parents:

Mother: _____ Father: _____

Who has legal guardianship of your child?
Who are other household members with your child?
Names Ages Relationship to child

Who are your child's significant others NOT living with your child?
Names ***Ages*** ***Relationship to child***

Please describe any past counseling that either your child or any family member

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____ if yes, please describe:

Education History:
What school does your child attend?

Address:

Phone: _____ Teacher's Name: _____
Current Grade: _____

What does your child's teacher say about him/her?

Other schools attended (including pre-school):

Has your child ever repeated a grade? If so which one(s)?

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

Fighting ***Lack of friends*** ***Drug/Alcohol*** ***Detention***

Suspension ***Learning Disabilities*** ***Poor attendance*** ***Poor grades***

Gang influence *Incomplete homework* *Behavior problems*

Medical History:
What is the name of your child's primary care physician? _____

Address: _____ Phone: _____

Date of your child's last medical examination: _____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems?

A serious accident ***Hospitalization*** ***Surgery*** ***Asthma***

A head injury ***High fever*** ***Convulsions/seizures***

Eye/ear problems ***Meningitis*** ***Hearing problems***

Allergies ***Loss of consciousness*** ***Other***

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?

Counseling History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the name of the therapists and/or programs (use back of this sheet if necessary):

Name of Therapist/Program	Issues Addressed	Dates in Treatment

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? **0** Yes **0** No

If yes, please describe: _____

Have any of your family or friends ever attempted or committed suicide? **0** Yes **0** No

If yes, who and when: _____

Medical History

Name and Town of Current Physician: _____

Date and outcome of last physical exam: _____

Please list any conditions, illnesses or surgeries that might be relevant to your reason for seeking counseling:

_____

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Please list current medications you are taking even if use is seldom or as needed (use back of sheet if necessary):

Name of Medication	Dosage	Reason for taking medication

Present Issues and Goals

Circle any of the flowing symptoms or problems that you are currently or have recently experienced:

0 Stress	**0** Grief	**0**Verbal abuse	**0**Impulsive behavior	**0** Anxiety
0 Chronic pain	**0** Sexual abuse	**0** Controlling	**0** Sexual problems	**0** Fears
0 Loneliness	**0** Sexual addiction	**0** Obsessive thoughts	**0** Depression	**0** Panic
0 Compulsive behavior	**0** Poor concentration	**0** Shyness	**0** Gender identity	**0** Anger
0 Fatigue	**0** Low self-esteem	**0** Hearing voices	**0** Loss of appetite	**0** Bad dreams
0 Marital problems	**0** Aggression	**0** Racing thoughts	**0** Trouble sleeping	**0** Apathy
0 Relational issues	**0** Eating problems	**0** Physical Abuse	**0** Unwanted memories	**0** Alcohol use
0 Feeling worthless	**0** Emotional Abuse	**0** Loss of control	**0** Pregnancy/Abortion	**0** Work issues
0 Financial issues	**0** Controlled by others	**0** Drug use	**0** Career choices	**0** Loss
0 Indecisiveness	**0** Spiritual apathy	**0** Seeing/Hearing things others don't		

Please describe why you are coming to counseling (issues, problems, symptoms, how long, etc.):

_____

_____

_____

Please circle on the scale below to indicate how distressing your problems are to you.

Very minimal distress Moderate distress Very extreme distress

Are you currently experiencing any suicidal thoughts? **0** Yes **0** No

Have you experienced suicidal thoughts or attempted suicide in the past? **0** Yes **0** No

Are you currently experiencing any violent or homicidal thoughts? **0** Yes **0** No

Please describe any of the following:

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_____
_____
_____

Referral Information

How did you find us (referred by doctor, friend, family, internet, EAP or other)? _____

_____