CHILD INTAKE ASSESSMENT FORM

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IDENTIFYING INFORMATION

Child's name: _____

Date of birth: _____ Age: _____ Grade: _____

Race/ethnicity: _____ Religious affiliation: _____

Social security number: _____

Person(s) completing this form: _____ Today's date: _____

Who suggested that you contact me: _____

Child's custodian/guardian(s) is/are: _____

Child's Home Address: _____

City _____ State _____ Zip Code _____

Home Telephone: _____ Other Phone (specify type): _____

Is it OK to contact you/child at home? ☐yes ☐no OK to leave a message? ☐yes ☐no

Special instructions? _____

Emergency Contact Name: _____ Relationship to Child: _____

Address: _____

City _____ State _____ Zip Code _____

Home Telephone: _____ Other Phone (specify type): _____

MOTHER'S INFORMATION

Mother's name: _____ Date of birth: _____ Home phone: _____

Address: _____

Race/ethnicity: _____ Religious affiliation: _____

Highest Grade Completed: _____

Marital/relationship status (Check one):

☐ Married ☐ Live with partner ☐ Single ☐ Separated/Divorced ☐ Widowed or ☐ Other: _____

Employment status (Check all that apply):

☐ employed ☐ retired ☐ disabled ☐ student ☐ homemaker ☐ unemployed

If/When employed, what type of work does mother do? _____

Current employer is: _____

Years on Current Job: _____ Business Phone: _____

Is it OK to contact mother at work? ☐ yes ☐ no OK to leave a message? ☐ yes ☐ no

Special calling instructions? _____

FATHER'S INFORMATION

Father's name: _____ Date of birth: _____ Home phone: _____

Address: _____

Race/ethnicity: _____ Religious affiliation: _____

Highest Grade Completed: _____

Marital/relationship status (Check one):

☐ Married ☐ Live with partner ☐ Single ☐ Separated/Divorced ☐ Widowed or ☐ Other: _____

Employment status (Check all that apply):

☐ employed ☐ retired ☐ disabled ☐ student ☐ homemaker ☐ unemployed

If/When employed, what type of work does father do? _____

Current employer is: _____

Years on Current Job: _____ Business Phone: _____

Is it OK to contact father at work? ☐ yes ☐ no OK to leave a message? ☐ yes ☐ no

Special calling instructions? _____

STEP-PARENT'S INFORMATION

Step-parent's name: _____ Date of birth: _____ Home phone: _____

Address: _____

Race/ethnicity: _____ Religious affiliation: _____

Highest Grade Completed: _____

Marital/relationship status (Check one):

☐ Married ☐ Live with partner ☐ Single ☐ Separated/Divorced ☐ Widowed or ☐ Other: _____

Employment status (Check all that apply):

☐ employed ☐ retired ☐ disabled ☐ student ☐ homemaker ☐ unemployed

If/When employed, what type of work does father do? _____

Current employer is: _____

Years on Current Job: _____ Business Phone: _____

Is it OK to contact father at work? □ yes □ no OK to leave a message? □ yes □ no

Special calling instructions? _____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems your child is experiencing: _____

_____

_____

_____

What has happened to cause you to seek help NOW?_____

_____

_____

What do you hope to be able to do or achieve as a result of treatment? _____

_____

_____

What do you consider to be other stresses in your child's life? _____

_____

HISTORY OF THE PROBLEM

When did your child first start experiencing the problem(s) that brought you to the clinic today?_____

_____

How often does the problem occur? _____

How long does it last? _____

Does your child have any thoughts of harming him/herself? No Yes

Has your child ever attempted to harm him/herself? No Yes If yes, please explain: _____

_____

Does your child have any thoughts of harming someone else? No Yes

Has your child ever attempted to harm someone else? No Yes If yes, please explain: _____

_____

Has your child ever had previous therapy/counseling of any kind? No Yes

If yes, when and for how long? _____

What concerns were addressed in therapy? _____

_____

Was this experience helpful (please explain)? _____

Has your child ever been hospitalized for emotional/behavioral problems? ☐No ☐Yes

If yes, when/where was this: _____

_____

Has your child been prescribed medications to control emotional/behavioral problems? ☐No ☐Yes

If yes, please list medications, when prescribed, and by whom: _____

_____

_____

To your knowledge, has your child experimented with alcohol/drugs? ☐No ☐Yes

Are you concerned that your child might have or be developing a problem with alcohol or drugs?

☐No ☐Yes If yes, please explain: _____

_____

FAMILY

Has this child ever experienced any parental separations, divorces, or death? ☐No ☐Yes

If yes, when? _____ How old was the child at the time? _____

Please describe the circumstances. _____

_____

If parents are separated or divorced, who has custody of this child? _____

How often does the other parent see this child? ____ Weekly or more often

____ Once or twice a month

____ Few times a year

____ Never

Please list the age and sex for each **sibling** (including those deceased, and step-siblings):

Age	Sex	Relationship to Child	Living at home?
			☐No ☐Yes
			☐No ☐Yes
			☐No ☐Yes
			☐No ☐Yes
			☐No ☐Yes
			☐No ☐Yes

Other than any children already indicated above and parents, who else lives in the child's household?

_____

_____

Has anyone in the child's family had treatment for emotional problems? ☐No ☐Yes

If yes, please briefly explain (who/when): _____

Has anyone in your family ever attempted or committed suicide? ☐No ☐Yes

If yes, please briefly explain (who/when): _____

FAMILY HEALTH

Describe father's present health: _____

Describe mother's present health: _____

Have any family members had any of the following (PLEASE CHECK IF YES)?

If yes, please specify family member's relationship to this child.

☐Cancer _____ ☐Severe head injury _____

☐Tourette's syndrome _____ ☐Cerebral palsy _____

☐Diabetes _____ _____ ☐Food allergies _____

☐Heart disease _____ ☐Alcohol/drug abuse _____

☐High blood pressure _____ ☐Kidney disease _____

☐Behavior disorder _____ ☐Migraine headaches _____

☐Depression _____ ☐Multiple sclerosis _____

☐Mental Illness _____ ☐Physical disability _____

☐Mental retardation _____ ☐Stroke _____

☐Nervousness _____ ☐Tuberculosis _____

☐Seizures/epilepsy _____ ☐Alzheimer's disease _____

☐Reading problem _____ ☐Other Learning Problem _____

☐Speech/language problem _____ ☐Sickle cell anemia _____

☐Attention Deficit/Hyperactivity Disorder _____

☐Sleep Difficulties _____ ☐Tics _____

☐Anxiety _____ ☐Bipolar Disorder _____

☐Other significant health or emotional problem: _____

What kinds of stressful events has your child and/or family members experienced recently?

_____

_____

_____

CHILD'S EDUCATION

School (name, address)	Grade	Age	Teacher	Approx. Grades

Describe any difficulties or problems your child is having in school: _____

_____

_____

CHILD'S DEVELOPMENT

Pregnancy and delivery

Was this a planned pregnancy? ☐No ☐Yes

Was the mother under a doctor's care? ☐No ☐Yes

Number of previous pregnancies/miscarriages: _____

Describe any complications that occurred during the pregnancy: _____

_____

What drugs/medications were used during the pregnancy? _____

_____

At this child's birth, what was the mother's age? _____ Father's age? _____

Length of pregnancy: _____ weeks Birth weight: ____ lbs ____ oz.

Length of labor: _____

Child's condition at birth: _____

Mother's condition at birth: _____

Length of stay in hospital: Mother _____ days Child _____ days

Is this child adopted? ☐No ☐Yes If yes, please provide adoption history: _____

_____

_____

_____

Was this child breast fed or bottle fed? ☐No ☐Yes If yes, when was she/he weaned? _____

At what age was this child toilet trained? Days: _____ Nights: _____

Did bed-wetting occur after toilet training? ☐No ☐Yes If yes, until what age: _____

Did soiling occur after toilet training? ☐No ☐Yes If yes, until what age: _____

CHILD'S DEVELOPMENT (continued)

Describe sleep patterns or problems: _____

_____

Language difficulties? ☐No ☐Yes If yes, describe: _____

_____

Delays with child's walking? ☐No ☐Yes If yes, describe: _____

_____

As a young child, did your child have problems getting along with others? ☐No ☐Yes

If yes, describe: _____

_____

Where there other problems experienced during the child's first year? ☐No ☐Yes

If yes, describe: _____

_____

CHILD'S MEDICAL CARE

Child's physician: _____ Telephone: _____

Address: _____

How often does this child see a doctor? _____ Date of last visit: _____

Is this child currently on any medication? ☐No ☐Yes

If yes, indicate type and reason: _____

_____

_____

Does your child have any history of the following (please check all that apply):

☐hospitalizations ☐surgeries ☐high fevers ☐serious accidents

☐eye, ear, nose & throat problems ☐digestive disorder ☐head injuries ☐seizures

☐loss of consciousness ☐serious illness ☐allergies

Please list below details of any conditions you checked above, including any additional childhood illnesses and other medical conditions:

Condition/hospitalization	Age	Treated by whom?	Outcome of treatment

CHILD'S INTERESTS AND ACTIVITIES

Is this child involved in any extracurricular activities, such as school sports or music programs, clubs or religious organizations? ☐No ☐Yes If yes, please describe: _____

_____

_____

Please describe your child's strengths and positive characteristics: _____

_____

_____

_____

_____

Other information you feel is important and wasn't asked about: _____

_____

_____

Thank you for your time and cooperation.

Jason G. Stentoumis, Psy.D.