Therapy To You

Home is where the healing is.

Child Intake Form

Please provide the following information about your child:

Full Name: _____

Nick Name: _____

Birth Date: _____ Today's Date: _____

What are the specific issues that have caused you to seek out therapy for your child and/or family?

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

What would you say some of your child's strengths are?

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

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Treatment Goals:

How will you know that your child and/or family will no longer need to see a therapist?

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?

Name	Age	Relationship to child
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Who are your child's significant others NOT living with your child?

Names	Ages	Relationship to child
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Please describe any past counseling that either your child or any family member. Include What you liked or what could have been better about the experience.

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)?

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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:

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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 or witnessed any type of abuse (physical, sexual, or verbal? If so, please describe:

Have you or your child ever had anything particularly scary, dangerous, or life threatening happen to you? ***Please include anything that may have happened to you during the years that your child has been alive, but that they may not necessarily be aware of.***

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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:

Anything else you think is or may be important for me to know?