Debbie Cherry, LMFT ~ www.LifeOnTheGrow.com
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CHILD CLIENT INTAKE FORM

Date: _____

Name: _____ DOB: _____ / _____ / _____ Age: _____

Parent/Guardian's name(s): _____

Residential Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Referred by: Online Search Physician Friend Professional Other: _____

Mother: _____ Father: _____
Occupation: _____ Occupation:_____
Home phone: (_____) _____ Home phone: (_____) _____
Cell phone: (_____) _____ Cell phone: (_____)_____

Parent / Guardian Relationship Status:
Are parents separated or divorced? Yes / No If yes, for how long? _____
If parents are separated/divorced, does non-custodial parent share legal custody? Yes / No
Are both parents aware that this child will be receiving counseling? Yes / No
Does child have contact with both parents? Yes / No How often?_____

Please list **all those living in your home** besides the child. This includes spouse, siblings, partner, friends and relatives. *Please use the back of this form if needed.*

Name	Age	Gender	Relationship to Child
		M / F	
		M / F	
		M / F	
		M / F	
		M / F	

Names, Ages, and Relationships of people living in the home: _____

_____

CHILD INTAKE QUESTIONNAIRE Client Name: _____

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What brought you into therapy today?_____

_____

How long has this been going on? _____

What do you wish to change or accomplish as a result of therapy? _____

_____

How long do you think that it may take to help with this issue? _____

Has the child been in therapy before? Yes / No If yes, please state when and where:

_____

Was it a positive experience? Yes / No What did you like/not like about it?

_____

What have you already tried to help with this problem? _____

_____

What are your child's strengths? _____

_____

What effect have these difficulties had on your family? _____

_____

What is the most challenging part of your relationship with your child? _____

_____

What do you enjoy most about your relationship with your child? _____

_____

Please describe your child's general mood: _____

_____

How is your child' eating and sleeping? _____

_____

What are your child's favorite things to do? _____

_____

What else would you like me to know about your child or family? _____

_____

_____

MEDICAL HISTORY **Client name:**

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Pediatric Office: _____ Doctor: _____

Address: _____ Phone: _____

Have you consulted a physician or psychiatrist regarding the problem that brings you here?

Yes / No Please elaborate: _____

Does your child have any current or past medical concerns? Yes / No

If Yes, Please describe: _____

Please list any current medications: _____

Has your child had any of the following? If yes, please explain:

Difficulty with pregnancy or birth? Yes / No _____

Concerns as a toddler? Yes / No _____

Head injuries? Yes / No If yes, did child lose consciousness? Yes / No _____

Hospitalizations? Yes / No _____

Surgeries? Yes / No _____

Serious illness? Yes / No _____

Trouble with drugs / alcohol? Yes / No _____

☐ Hearing difficulties ☐ Eye/Vision problems ☐ Asthma

☐ Sensory problems (i.e. doesn't want to touch certain textures; bothered by bright lights)

☐ Fine motor problems (handwriting, cutting, using fingers)

☐ Gross motor problems (clumsy, poor balance, trouble running)

SCHOOL & SOCIAL HISTORY

School: _____Grade: _____ Teacher _____

Has your child attended other schools? No / Yes : How many? _____

What prompted the change? _____

Overall, how is your child's academic progress? ☐ excellent ☐ good ☐ fair ☐ poor ☐ struggling

_____

Does your child receive any special services?

☐ tutoring (in school/ private) ☐ occupational/speech/physical therapy ☐ 504 plan ☐ IEP

Other: _____

Have you ever been called to pick your child up at school due to misbehavior? No / Yes

Has your child ever had detention, been suspended or asked to leave a school? No / Yes

Does your child have close friends? No / Yes : How many? _____

Does your child participate in groups activities or hobbies? _____

_____

Child's Name: _____

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Child and Family History - Please indicate any that child has experienced:

___ Parent injury/ illness/hospitalization
___ Unemployment of family member
___ Alcohol or drug abuse by family member
___Abuse (Sexual, emotional, verbal, physical)
___Violence in the home
___Violence in the community
___ Family members that have been arrested
___ Family members that have been incarcerated
___ Police confrontation/arrest of parent/guardian
___ Death in the family
___ Conflict between parents
___ Witness to drug abuse
___ Financial stress for caregiver
___ Exposure to a traumatic event
___ Car accident
___ Home robbery/invasion
___Disaster (natural/other)
___ Frequent moves

Please elaborate on any of the above: _____
_____
_____

Family Mental Health History – *Family history is important to understanding your child's behavior and treatment. Please indicate below if anyone in the family has experienced the following.*

Has anyone experienced:	**Mother's Side**	**Father's Side**
Anxiety		
Depression		
Bipolar disorder		
Learning disorders (ADHD, dyslexia…)		
Drug abuse		
Alcohol abuse		
Schizophrenia		
Suicide attempts		
Completed suicide		
Panic Attacks		
Collecting useless items		
Violent temper		
Abuse (Physical/ Emotional/ Verbal / Sexual)		
Hallucinations or Delusions		
Strange behavior or thinking		
Other:		

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Child's Name:_____

BEHAVIOR CHECKLIST: Please check items that describe your child's behavior for the **past year:**

□ Academic problems/homework difficulties	□ Not interested in things
□ Angry mood/Rages	□ Paying attention; focusing difficulties
□ Anxiety	□ Perfectionism
□ Arguing	□ Mood goes up and down
□ Being bullied or bullying	□ Repetitive habits
□ Blames others	□ Rigid routines
□ Bossiness	□ Unusual behavior
□ Nightmares/Night terrors	□ Self injury
□ Crying frequently	□ Separation anxiety
□ Defiant (to parents or other adults)	□ Sexualized behavior (that seems inappropriate)
□ Destroys things	□ Shyness (excessive)
□ Disorganized, loses things	□ Sleeping, waking difficulties
□ Doesn't want to try new things	□ Somatic complaints (headaches/stomachaches)
□ Eating issues (too much, too little)	□ Stealing
□ Easily frustrated	□ Strong feelings of guilt or shame
□ Emotional outbursts	□ Suicide attempts
□ Fears	□ Suicidal thoughts (says wants to die)
□ Forgetfulness	□ Talking back, yelling
□ Frequent conflict	□ Tantrums
□ Grief/loss	□ Threats or comments about hurting self
□ Hair pulling	□ Threats or comments about hurting others
□ Hard to make/keep friends	□ Too concerned with neatness
□ Hears or sees things others do not	□ Toileting
□ Hits others	□ Transitions are difficult
□ Hurts animals	□ Strong reactions to textures, light, sound
□ Hyper; trouble sitting still	□ Unhappy, sad or depressed
□ Impulsive	□ Unusual thoughts
□ Irritable	□ Wetting/ soiling pants or bed
□ Lack of confidence	□ Withdrawn; not sociable
□ Learning and remembering difficulties	□ Worries a lot