Integrated Therapy Services

Child Information Intake Form

Please answer the following as completely as possible. Use the back if additional space is needed.

Child's Name: _____ Date: _____
(Last) (First) (Middle Initial)

Gender: F___ M___ Ethnicity: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (cell) _____ (work) _____
Ok to leave a message? YES/NO YES/NO YES/NO

In the event of an emergency contact: _____ Phone: _____

Parent/Caregiver: _____ Occupation/Company: _____

Parent/Caregiver: _____ Occupation/Company: _____

Circle which parent/caregiver above is bringing child for treatment today.

Biological Parents Are: Married/Separated/In Process of Divorce/Divorced/Deceased/In a committed relationship/Never Married/No Longer Together/ Unknown

Child Resides With:

Name	Age	Relationship to Client

Additional Family Members/Caregivers:

Name	Age	Relationship to Client

Referred to this office by: _____

School/Daycare: _____ Grade: _____ Teacher: _____

Does your child receive any accommodation or services at school? If yes, please describe:

_____

_____

Pediatrician's Name: _____ Phone:_____

Date Last Seen: _____ Reason: _____

Medications: _____

Allergies: _____

Medical Issues/Surgeries/Accidents: _____

_____

Previous Counseling or Evaluations? Yes/No

If yes, with whom: _____When:_____

Reason for previous counseling/evaluation: _____

_____

Psychiatrist Name: _____ Phone: _____

Did your child reach developmental milestones at age appropriate times? Yes/No

If no, please explain: _____

_____

Please describe any difficulties related to pregnancy/birth/postpartum: _____

_____

Circle any of the following that are supportive influences in your child's life:

Extended family	Faith based support	Cultural or ethnic resources
Other counselors	Doctor	Physical therapy
Employer	School	Child care
Friends	Community Resources	Other: _____

Circle any of the following you or your child has experienced or been involved with:

Physical Abuse	Emotional Abuse	Sexual Abuse	Incest
Birth Concerns	Depression	Suicide Attempt	Death of a Loved One
Major Illness/surgery	Divorce	Disability	Separation
Miscarriage	Abortion	Homelessness	Parental Incarceration
Drug Use	Eating Disorders	Failure to Thrive	Domestic Violence

Other: _____

Are there any concerns with:

Drug/Alcohol Use - Yes/No (*If Yes, Please Explain)* _____

Mental Health - Yes/No (*If Yes, Please Explain)*_____

Parenting - Yes/No (*If Yes, Please Explain)*_____

How would you rate your child's over all functioning? (circle one)

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Unable to function in all areas		Unable to function in most areas			Serious difficulty functioning		Mild to moderate difficulty		Minimal to no difficulty

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Please indicate if your child has experienced any of the following in the past 6 months:
(0= None; 1= mild; 2= moderate; 3= severe; 4= extreme; 5= very extreme)

	#		#
Relationship problems with siblings		Fears	
Problems with other children		Upset stomach	
Parent-child difficulties		Vomiting	
Death of someone close to child		Difficulty with bowel movements	
Nervousness		Weight problems (loss/gain)	
Moodiness		Eating problems	
Temper tantrums		Change in appetite	
Very Active		Fatigue	
Tension		Anxiety	
Easily upset		Sleep problems	
Crying		Encopretic (soiling self)	
Feels unhappy		Enuretic (wetting self)	
Lacks self-confidence		School problems	
Feels lonely		Poor speech/language skills	
Destructive behavior		Vision/ hearing difficulties	
Anger		Poor coordination	
Irritability		Discipline problems	
Easily distracted		Stealing	
Confusion		Sexualized behavior	
Obsessions		Aggression	
Phobias		Fidgety/Restlessness	
Nightmares		Excessive worry	
Depression		Boredom	
Memory problems		Fighting	
Lying/dishonesty		Problems Concentrating	
Other:		Other:	

To be completed by Client/Child:

What are some of your strengths? What do you like about yourself?

_____

_____

_____

What do you do for fun? _____

_____

_____

How many close friends do you have? Would you like this to be different in any way?

_____

_____

_____

What do you like most about school? What do you like least about school?

_____

_____

_____

Do you participate in any after school activities? What are the activities?

_____

_____

_____

TREATMENT PLAN- Briefly state why you are seeking counseling. What do you hope to change?
Our goals for counseling are:

1.

2.

3.

Notes:

Are you concerned with any of the following:

Suicidal thoughts, plans, attempts?

_____

_____

Fear for your life or your safety?

_____

_____

Depression/Lack of care for self?

_____

_____

In signing below, I affirm that the information given is true and complete to my knowledge.

_____ _____

Parent/Guardian Signature ***Date***

_____ _____

Client Signature ***Date***

_____ _____

Therapist Signature ***Date***