Child Intake Assessment Form

Full name:

____
Last First Middle Initial

Birth Date ___/___/____ **Age:** _____ **Gender & Pronouns** ________________

Person filling out form & relation to child:

____

Name of person responsible for bill:

____

Emergency Contact Name and Relation to Client ____________________________
Emergency Contact's Phone ____________________________

Parents / Stepparents

Mother's name: ____________________ Age: _____ Occupation: ______________________
Father's name: ____________________ Age: _____ Occupation: ______________________

Marital status of parents: ____________________ *If parents are separated/divorced, how old was the child at time of separation?* _______________

With whom does the child live?

____

Custody:

❑Lives in one home with both legal parents. ❑Mother has physical custody.
❑Father has physical custody. ❑Physical custody is shared. ❑Other: ____________________

List all people living in household:

Name - Age - Relationship to child

____
____
____
____
____
____

If any brothers or sisters are living outside the home, list their names and ages:

____
____

If any brothers / sisters are deceased, please give name and year:

____

FAMILY INFORMATION:

Was the child adopted? ❑Yes ❑No If yes, at what age? ________

Has the child ever been placed outside of the home? ❑Yes ❑No

If yes, where? ____

In how many residences has the child lived since birth?

____

Has the child been physically or sexually abused, assaulted or molested? ❑Yes ❑No ❑Don't know

If yes, specify by whom and when:

____

Have the child's parents or any other family members had any mental health or emotional problems? ❑Yes ❑No If yes, describe:

____

____

____

PRESENTING PROBLEM:

Briefly describe your child's current difficulties:

____

____

____

____

____

When was the problem first noticed?

____

____

What seems to help the problem?

____

____

What seems to make the problem worse?

____

____

Has the child received evaluation or treatment for the current problem or similar problems? Yes ___ No ___ If yes, when and with whom?

____

How do you want your child's situation to be different after coming here?

SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits.

_____ Has difficulty with speech
_____ Has frequent tantrums
_____ Cries easily and often
_____ Has difficulty with hearing
_____ Has frequent nightmares
_____ Has difficulty with language
_____ Has trouble sleeping (describe)
_____ Has difficulty with vision
_____ Has blank staring spells
_____ Has difficulty with coordination
_____ Rocks back and forth
_____ Prefers to be alone
_____ Bangs head
_____ Does not get along well with other children
_____ Holds breath
_____ Is aggressive
_____ Eats poorly
_____ Is shy or timid
_____ Is stubborn
_____ Has poor bowel control (soils self)
_____ Is much too active
_____ Is more interested in things (objects) than in people
_____ Engages in behavior that could be dangerous to self
_____ Has special fears, habits, or mannerisms
_____Is impulsive
_____Show daredevil behavior
_____Sucks thumb
_____ Gives up easily
_____Is slow to learn
_____ Wets bed
_____Other (describe): ____________________ ____

Elaborate on those items you checked, below:

____
____
____
____
____

Describe child's relationship with his / her:

Father

Mother

Sibling(s)

Other family members

OTHER INTERPERSONAL RELATIONSHIPS:

How do you describe the child's friendships:
❑No Friends ❑Only Acquaintances ❑Both acquaintances and close friends
How many close friends? ___________

EDUCATIONAL HISTORY
School: ____ Grade: ___________

Does your child like school? **Yes** ___ **No** ___

Does your child struggle in school? **Yes** ___ **No** ___. **If yes, how so?**

DEVELOPMENTAL HISTORY
During pregnancy, was mother on medication? **Yes** ____ **No** ____ **If yes, what kind?**

During pregnancy, did mother smoke? **Yes** ____ **No** ____ If yes, how many cigarettes each day? ____

During pregnancy, did mother drink alcoholic beverages? **Yes** ____ **No** ____ If yes, what and how much did she drink?

During pregnancy, did mother use drugs? **Yes** ____ **No** ____If yes, what kind?

Were forceps used during delivery? **Yes** ____ **No** ____

Was a Cesarean section performed? **Yes** ____ **No** ____If yes, for what reason?

Was the child premature? **Yes** ____ **No** ____ If so, by how many months? _____

What was the child's birth weight?

Were there any birth defects or complications? **Yes** ____ **No** ____ If yes, please describe:

Were there any feeding problems? **Yes** ____ **No** ____ If yes, please describe:

Were there any sleeping problems? **Yes** ____ **No** ____If yes, please describe:

As an infant, was the child quiet? **Yes** ____ **No** ____

As an infant, did the child like to be held? **Yes** ____ **No** ____

Were there any special problems in the growth and development of the child during the first few years? **Yes** ____ **No** ____If yes, please describe:

Following pregnancy and birth, did mother suffer any postpartum symptoms (depression, psychosis)? Yes ____ **No** ____If yes, please describe:

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Age of behavior

____Showed response to parent ____Put several words together ____Rolled over
____Dressed self ____Sat alone ____Became toilet trained ____Crawled
____ Stayed dry at night ____Walked alone ____ Fed self ____Babbled ____
Rode tricycle ____Spoke first word

CURRENT HEALTH INFORMATION:

Describe child's health generally: ❑Good ❑Fair ❑Poor

Is the child sexually active? ❑No ❑Yes

List any health problems the child has had:

____
____
____

Does the child have:
Current immunizations ❑No ❑Yes Which are needed? ______________________
Any allergies ❑No ❑Yes Specify ____
Nutritional problems ❑No ❑Yes Specify __________________________________
Appetite problems ❑No ❑Yes Specify ____________________________________
Sleep problems ❑ No ❑Yes Specify______________________________________
Disability or handicap ❑ No ❑Yes Specify ________________________________
Contagious or other diseases ❑No ❑Yes Specify ___________________________
Any accidents / injuries ❑No ❑Yes Specify__________________________________
Dental, vision or hearing problems ❑No ❑Yes Specify ________________________
Any hospitalizations ❑No ❑Yes Specify ---------------------------------

Physician name:
____
Date of last contact: ____ / ____ / ____
Reason for last contact: ______________________________

SUBSTANCE USE / ABUSE:

Has the child ever used any of the following substances? Place a "*" next to those you know or believe him or her to be using now.

Alcohol ❑No ❑Yes
Stimulant ❑No ❑Yes
Cocaine ❑No ❑Yes
Tranquilizer ❑No ❑Yes
Barbituate ❑No ❑Yes
Opiod ❑No ❑Yes
Hallucinogen ❑No ❑Yes
Prescribed ❑No ❑Yes
Nicotine ❑No ❑Yes
Caffeine ❑No ❑Yes
Other ❑No ❑Yes

FAMILY MEDICAL HISTORY:
Place a check next to any illness or condition that any member of the child's family has had. When you check an item, please note the member's relationship to the child.

Check Condition **Relationship to child**

_____ Alcoholism _____________________________________

______ Depression ____________________

______ Cancer ____________________

______ Learning disability ____________________

______ Diabetes ____________________

______ ADHD ____________________

______ Heart trouble ____________________

______ Developmental Delay ____________________

______Autism ____________________

______ Bipolar Disorder ____________________

______ Anxiety Disorder ____________________

______ PTSD ____________________

______ Other ____________________

RELIGION / SPIRITUALITY:
Religion: ❑Protestant ❑Catholic ❑Buddhist ❑Hindu ❑Jewish ❑Muslim ❑Atheist ❑Agnostic
❑Other: ____________________

LEGAL INFORMATION:

Has the child ever: Had difficulty or contact with police?❑Yes ❑No
Appeared in a Juvenile Conference? ❑Yes ❑No
Been on probation? ❑Yes ❑No
Please explain:
____
____
____

OTHER INFORMATION:
What are your child's favorite activities?
1.____________________
2.____________________

3. ____

4. ____

5. ____

6____

What activities does your child like least?

1.____

2.____

3. ____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

Check Disciplinary technique

______ Ignore problem behavior
______Tell child to sit on chair
______ Scold child
______ Send child to his or her room
______ Spank child
______ Take away some activity or food
______ Threaten child
______ Reason with child
______ Redirect child's interest
______ Don't use any technique
______ Other technique (describe) ____

Which disciplinary techniques are usually effective?

____

____

Which disciplinary techniques are usually ineffective?

____

____

What have you found to be the most satisfactory ways of helping your child?

____

____

What are your child's assets or strengths?

____

____

____

PREVIOUS COUNSELING / PSYCHOTHERAPY:

Has your child ever been in counseling / therapy before? ❑No ❑Yes
Name of Provider/Clinic Year Diagnosis / Problem

Has your child been prescribed psychotropic medication? ❑No ❑Yes

Medication: ______________________ Dosage: ___________

Prescribed by: ____________________

Medication: ______________________ Dosage: ___________

Prescribed by: ____________________

Reason:

Other medications currently prescribed:

Medication: ______________________ Dosage: ___________

Prescribed by: ____________________

Medication: ______________________ Dosage: ___________

Prescribed by: ____________________

Has the child ever:
Made a suicide attempt: **❑No ❑Yes** If yes, when?
____
Expressed homicidal thoughts: **❑No ❑Yes** Describe
_______________________________ Had episodes of explosive anger: **❑No ❑Yes**
Describe _____________________________
Is the child currently expressing homicidal / suicidal feelings? **❑No ❑Yes**

* *

Signature of Informant
____Date _______________

Relationship to client ____