INTAKE INFORMATION – CHILD

Today's Date _____

Client Name: _____ Age: _____DOB:_____

Form completed by: _____

PARENT AND FAMILY INFORMATION:

Partner/Spouse: _____

Home Address: _____
Street City State Zip

Phone: _____
Home Work Cell

Where do you prefer that I call you and can leave a message?_____

Emergency Contact : _____
Name Relationship Phone

Who referred you to Khristina Williams, LMHC, LPC?_____

PARENT/CAREGIVER:

1. Are you employed outside the home? ☐ Yes ☐ No Where/Job title/ for how long?

_____

_____

2. Education: Are you currently in school? ☐ Yes ☐ No

If yes where?_____

3. Household members (other than yourself):
Full Name Date of Birth/Age Relationship

_____

_____

_____

_____

_____

4. Briefly describe the problem that brought you here: _____

_____

_____

_____

_____

5. What do you hope the child will gain from therapy? _____

_____

_____

_____

_____

BIRTH HISTORY AND CHILD DEVELOPMENT

Please answer these questions as best you can. If you do not know the answer or prefer not to answer leave it blank.

Pregnancy: Is this your ☐ biological child ☐adopted child ☐other _____

Pregnancy was ☐ planned ☐ unplanned

Mother's age during pregnancy _____ Length of Pregnancy _____

Did the mother see a physician regularly ? _____

Were there any difficulties in the pregnancy? Check all that apply:

- ☐ Bleeding or spotting
- ☐ High blood pressure
- ☐ Frequent Headaches
- ☐ Weight gain over 35 lbs
- ☐ Accidents, Falls, Injuries
- ☐ Infectious disease
- ☐ Other Physical Illness
- ☐ Jaundice
- ☐ Special Diet
- ☐ Emotional stress
- ☐ Tobacco Use
- ☐ Alcohol use
- ☐ Drug Use
- ☐ Vomiting
- ☐ Toxemia

Medications taken during pregnancy _____

Other Difficulties _____

BIRTH HISTORY:

Due Date _____ Date of Birth _____

Baby was born ☐ in Hospital ☐ At home ☐ Other

Length of stay in hospital for: Mother _____ Baby _____

Labor was ☐ Easy ☐ Difficult ☐ Induced ☐ As Expected ☐ Very different than expected

Any birth complications? _____

_____

Who was present at the birth? _____

_____

Any immediate health problems for the baby at birth?_____

_____

Anything else you feel that is important for me to know about the pregnancy or birth experience? _____

_____

INFANCY: Please check any of the following that were a problem in the first year of this child's life.

- ☐ Bonding problems (it is hard to feel positively connected to this baby)
- ☐ Feeding problems
- ☐ Sleep problems
- ☐ Illnesses
- ☐ Breathing Troubles
- ☐ Colic, excessive crying
- ☐ Allergies
- ☐ Hard to comfort
- ☐ Needed medication
- ☐ Frequent Vomiting
- ☐ Parent(s) felt alone and isolated
- ☐ Frequent prolonged Crying
- ☐ Baby was very sensitive to stimulation (sound, light, temperature, etc…)
- ☐ Baby did not like cuddling or being held
- ☐ Failed to develop as expected
- ☐ Short attention span
- ☐ Hard to distract or entertain
- ☐ Baby hard to take anywhere
- ☐ Mother felt depressed or "blue"
- ☐ Physical/emotional wellness of parent a problem
- ☐ Addiction problem of parent
- ☐ Problems with baby's siblings
- ☐ Very Demanding baby
- ☐ Economic stressors on family/work related problems or changes
- ☐ Major crisis during child's first year of life _____

Other: _____

Are there any other comments you would like to make about pregnancy, birth experience, or the first year of this child's life? _____

_____

_____

HEALTH HISTORY

Please answer by indicating yes or no. We will discuss as necessary.

a. In general is this child healthy? ☐ Yes ☐ No

b. Do you worry about this child's physical health? ☐ Yes ☐ No

c. Are there physical or mental health problems in this child's biological family that your worry your child might inherit? ☐ Yes ☐ No

d. Has this child ever been given psychological tests? ☐ Yes ☐ No

e. Has this child or either parent ever been in counseling or psychotherapy? ☐ Yes ☐ No

f. Has this child or either parent ever been on medications to change mood, modify behavior or change activity level? ☐ Yes ☐ No

g. Has this child or anyone in the family been in drug or alcohol treatment? ☐ Yes ☐ No

h. Has this child ever been involved in the juvenile justice system? ☐ Yes ☐ No

i. Primary Care Physician : _____ Phone: _____

Have you ever been, or are you now, concerned or worried about your child's

☐ Health or development during pregnancy
☐ Health at birth
☐ Infant development
☐ Eating habits
☐ Dizzy spells or loss of consciousness
☐ Speech Development
☐ Ability to learn
☐ Degree of responsibility
☐ Fearfulness
☐ Hearing
☐ Mood Swings
☐ Anger
☐ Physical Health
☐ Weight
☐ School Achievement
☐ Vision
☐ Smoking or use of Alcohol/Drugs
☐ Anxiety level of anxiety attacks
☐ Shyness
☐ Sleep Patterns or night Behavior
☐ Sensitive to light, sound temperature or touch
☐ Nightmares/ Night terrors
☐ Ability to move from one activity to another without getting upset
☐ Sexual activity
☐ Enuresis (wetting)
☐ Encopresis (soiling)
☐ Nail biting, thumb sucking, hair pulling
☐ Relationships with family members
☐ Relationships with others
☐ Self -destructive behaviors
☐ Play habits
☐ Sexual identity
☐ Adjustment to school
☐ Amount of TV time
☐ Lack of attention
☐ Lack of motivation
☐ Depression

LIFE EVENTS

We will be talking about the following in more detail. For now, please put a check mark by all those that apply to your child.

		Child's age
☐	Adoption	_____
☐	Death of Mother	_____
☐	Death of Father	_____
☐	Death of Sister/Brother	_____
☐	Desertion of Mother	_____
☐	Separation of Parents	_____
☐	Divorce of Parents	_____
☐	Parent's alcohol or drug problems	_____
☐	Mental illness of immediate family members	_____
☐	Long term or major physical illness of family member	_____
☐	Separation from significant caregiver	_____
☐	Emotional abuse	_____
☐	Sexual abuse	_____
☐	Physical abuse	_____
☐	Frequent or long term separation from a parent	_____
☐	Serious illness or serious accident of self	_____
☐	Serious illness or serious accident of family member	_____
☐	Natural Disaster (fire, flood, earthquake, hurricane)	_____

How many times have you moved during this child's life?_____

Have any of the adults parenting this child experienced a major crisis or trauma during this child's life? ☐ Yes ☐ No

Notes/Comments:

_____

_____

_____

_____

_____

_____

_____

_____

SCHOOL HISTORY / DAY CARE HISTORY

Type of class your child is attending now: ☐ Regular ☐ Special Ed. ☐ Other _____ ☐ None

Are you satisfied with this placement ☐ Yes ☐ No

In the past, has your child ever experienced special help or special classes in school?

☐ Yes ☐ No If yes, please explain: _____

_____

_____

_____

Have any of the child's brother or sisters had problems is school? ☐ Yes ☐ No

Did the child's mother, father or other relatives have learning problems in school?

☐ Yes ☐ No If yes, please explain: _____

_____

_____

_____

Is the child's behavior satisfactory at school? ☐ Yes ☐ No If no, please explain: _____

_____

_____

_____

_____

How does the child feel about school? _____

_____

_____

_____

_____

What does his/her teacher think are your child's strengths and weaknesses? _____

_____

_____

_____

Had the school done any psychological testing with your child? ☐ Yes ☐ No

Is there anything else you want to tell me about this child's school experience? _____

_____

_____

_____

_____

CURRENT PERSONALITY AND BEHAVIORS

How would you describe your child at this current time? Please check all that apply:

- ☐ Aggression/ Fighting
- ☐ Alcohol Abuse
- ☐ Angry outbursts
- ☐ Arguments/Conflicts
- ☐ Anxiety
- ☐ Avoiding People
- ☐ Chest Pain
- ☐ Depression
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Elevated Mood
- ☐ Temper tantrums
- ☐ Irritable
- ☐ Sneaky
- ☐ Mean/hurtful, physically or verbally
- ☐ Will ask for help when needed
- ☐ Worries about parents
- ☐ Overly dependent
- ☐ Restless
- ☐ Feels "Dumb"
- ☐ Is happy with friendships
- ☐ Tells lies
- ☐ Cries easily or a lot
- ☐ Gets along with sister(s)
- ☐ Difficulty separating from parents
- ☐ Affectionate
- ☐ Accepted by other children
- ☐ Thinks parent like him/her
- ☐ Is easily/often frustrated
- ☐ Likes quiet play
- ☐ Complains about health
- ☐ Fights easily/often
- ☐ Likes physical contact, hugs, cuddling and snuggling
- ☐ Fatigue
- ☐ Gambling
- ☐ Hallucinations
- ☐ Heart Palpitations
- ☐ High Blood Pressure
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment Errors
- ☐ Loneliness
- ☐ Memory Impairment
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Phobias/fears
- ☐ Fearful
- ☐ Sensitive
- ☐ Likes to try new things
- ☐ Gets along with Mother
- ☐ Gets along with Father
- ☐ Affectionate
- ☐ has a sense of the future
- ☐ Enjoys learning
- ☐ Daydreaming
- ☐ Feels "left out"
- ☐ Is proud of Self when does well
- ☐ Usually follows directions
- ☐ Gets along with brother(s)
- ☐ Lets others comfort if angry or hurt
- ☐ Prefers to comfort self if upset
- ☐ Considers self part of family
- ☐ Acts young for his/her age
- ☐ Show appreciation
- ☐ Recurring Thoughts
- ☐ Sexual Addiction
- ☐ Frequent Illness
- ☐ Sleeping Problems
- ☐ Speech Problems
- ☐ Suicidal Thoughts
- ☐ Suicidal Plans
- ☐ Suicidal Attempts
- ☐ Thoughts Disorganized
- ☐ Trembling
- ☐ Withdrawing
- ☐ Worrying
- ☐ Needs lots of supervision
- ☐ Wishes they were the opposite sex
- ☐ Shares feelings
- ☐ Can entertain self happily
- ☐ Overly Responsible
- ☐ Likes School
- ☐ Content/Often Happy
- ☐ Is liked by most adults
- ☐ Expresses likes/dislikes appropriately
- ☐ Feels "rejected" by peers
- ☐ Likes Self
- ☐ Preoccupied with Food
- ☐ Rebellious
- ☐ Feels guilty
- ☐ Completes most tasks
- ☐ Disobedient
- ☐ Can stay in timeout
- ☐ Disorganized/Messy
- ☐ Likes self
- ☐ Steals/takes things
- ☐ Accidents, gets hurt frequently
- ☐ Avoids responsibility

☐ OTHER (Specify) _____

_____

_____

_____

List any other important behaviors or feelings you want to mention: _____

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Thank-you for taking the time to answer these questions. Your responses will help us focus our work and decide which approach will be most helpful in working on the issues that brought you here.