INTAKE FORM FOR PARENT/GUARDIAN OF A MINOR CLIENT

Today's Date: ________________

IDENTIFICATION:

Your Name: ____________________ Relationship to the child: _________

Child's Full Name: ____

Child's Date of Birth: _____/______/________

Child's Current Age: __________ Gender: Male ☐ Female ☐

Home Address: _____________________________________

____

Home Telephone Number: _______________ Cell: ___________________

E-mail address for Parent/Guardian:

____

BIRTH HISTORY:

Is your child adopted? ☐ Yes ☐No - If yes, at what age? ____________

Where was your child born? _____________________________________

Were there any problems during the pregnancy or birth? ______________

____

Did the child's mother smoke tobacco, use alcohol, drugs or medications during the pregnancy? ☐Yes ☐No

If yes, please list which ones? ___________________________________

Did the child's mother feel depressed after the baby's birth? ☐Yes ☐No

How well do you feel that mother/child bonded after baby's birth? _______

____

Developmental Milestones: Please rate your child on each of the following using scale of:
A= Average S= Slower than Average F= Faster than Average U=Unknown

___Smiled ___Sat up without support ___Stood ___Walked

___Fed Self ___Said 1st word ___Said phrases ___Read

Please explain any milestone rated other than A (average): ______________
____
____

ABOUT THE CHILD'S FAMILY:

Name of the biological parents:

Mother: _________________________ Father: _________________________

Marital Status of the Biological Parents: _______________________________

Who has legal guardianship of the child? _______________________________

Is there a custody agreement with another parent/guardian? ☐Yes ☐No
If Yes, please describe the agreement. (If custody is shared, please indicate if your agreement requires permission from both parents/guardians for the minor to receive counseling services) ____
____

Primary languages spoken in the child's home? ________________________

Child's ethnicity and cultural background? _____________________________

Please list family members:

RELATIVES	NAMES	AGE	DOES CHILD GET ALONG W/ HIM/HER?	GRADE/OCCUPATION
FATHER				
MOTHER				
SISTER (S)				
BROTHER (S)				
STEP-FATHER (S)				
STEP-MOTHER (S)				
STEP-BROTHER (S)				
STEP-SISTER (S)				
ANYONE ELSE WHO LIVES WITH CHILD				

In your family, including yourself, was there:

A. Alcoholism? Yes ☐ No ☐ Father/Mother/Siblings/Self
How Long? ______________________
Current Status: ____
B. Substance Abuse? Yes ☐ No ☐ Father/Mother/Siblings/Self
How Long? _____________________
Current Status: ____
C. Mental Illness? Yes ☐ No ☐ Father/Mother/Siblings/Self
How Long? _______________________
Current Status: ____
D. Serious Illness: Yes ☐ No ☐ Father/Mother/Siblings/Self
How Long? ________________________
Current Status: ____

List any major changes, including marriages, divorces, moves, deaths etc. which have occurred in your family, in the past 5 years.

____
____
____
____

What stresses does your family struggle with?

____
____
____

ABOUT YOUR CHILD'S EDUCATION:

What school does your child currently attend?

____

Current Grade: ___________

Has your child ever skipped or repeated a grade? Yes ☐ No ☐

If yes, which one(s)? ____________ was skipped/repeated (circle one)

Child's Favorite Class(es)/Subject(s): _________________________________

Least Favorite Class(es)/Subject(s): _________________________________

Has your child ever received special education services? Yes ☐ No ☐

If yes, please elaborate(under what classification):

____

Has your child received any academic or psychological testing done at school or elsewhere? Yes ☐ No ☐ If Yes, when and where?

____
____

What do school teachers tell you about your child?

____
____

Has your child experienced any of the following problems at school? (check all that apply)

___fighting ___lack of friends ___drugs/alcohol

___suspension ___learning disabilities ___poor attendance

___gang influence ___incomplete homework ___bullying

___poor grades ___emotional issues ___behavioral issues

ABOUT YOUR CHILD'S ROUTINE:

What kinds of physical exercise does your child engage in? _______________

____

Are there any issues surrounding eating that you have observed with your child?

____

____

Average Bedtime: ______________ Average Wake-up time: ________________

Does your child have any problem getting enough sleep? Yes ☐ No ☐ If yes, please describe: ____

ABOUT YOUR CHILD'S HEALTH:

Who is your child's pediatrician? _______________________________________

When was the last visit? ____

Any concerns shared by the doctor? ____________________________________

Are there currently any medical concerns?

____

____

____

List all medications your child takes or has taken in the last year:

____

____

YOUR CHILD'S SOCIAL INFORMATION:

Please describe any past/current traumas that your child has experienced (including abuse, physical, sexual, verbal etc.)

____

____

____

Please describe your child's interaction with adults:

____

____

____

Please describe your child's interaction with other children:

___

___

___

Does your child engage in any of the following:

☐ Video Games ☐Facebook ☐online/computer time

If yes, how often and for how long for each?

___

How would you describe your child's personality and or temperament?

___

___

___

Please include any additional information that you feel is important regarding your child:

___

___

___

___

YOUR CHILD'S TREATMENT HISTORY AND GOALS:

Has your child received previous counseling? Yes ☐ No ☐ If yes, please list previous dates of treatment, any diagnosis etc:

___

___

___

Has your child ever made statements of wanting to hurt him/her self?

Yes ☐ No ☐ If yes, please describe the situation:

___

___

Has your child ever made statement of wanting to seriously hurt someone else?

Yes ☐ No ☐ If yes, please describe the situation:

___

___

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent/caretaker)? Yes ☐ No ☐
If yes, please explain: ___

___

___

Has anyone in your child's family been diagnosed with depression, anxiety, or any other mental health problems? Yes ☐ No ☐ If yes, please describe:

____
____
____

What is your main concern? ____
____
____
____

What do you think are some things that might cause this problem?

____
____
____

What are some of your child's strengths? ___________________________________
____
____

What are some of the outcomes that you could like to see as a result of therapy for your child? ____
____
____
____