

Child Initial Intake Form

** indicates a required field*

*** Today's Date:**

*** Client Name:**

*** Preferred Name:**

*** DOB:**

*** Age:**

*** Home Address:**

*** Name of School:**

*** Grade Level:**

*** Phone:**

*** Parent/Guardian name:**

*** Relation to Client:**

*** Email:**

*** How did you hear about us?**

- ☐ Family/Friend
- ☐ Physician/Psychiatrist
- ☐ Social Media
- ☐ Internet Search
- ☐ Psychology Today

*** Referral Name:**

*** May I have your permission to thank this person for the referral?**

☐ Yes

☐ No

*** If referred by another clinician, would you like for us to communicate with one another?**

☐ Yes

☐ No

*** Person to notify in case of emergency:**

*** I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so (Your signature):**

*** Please briefly describe your presenting concern(s):**

*** What are your goals for therapy?**

*** How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?**

Medical History

*** Please explain any significant medical problems, symptoms, or illnesses:**

*** Current Medications (Please provide name of medications, dosages, purposes, and name of prescribing doctors):**

*** Previous medical hospitalizations (Approximate dates and reasons):**

*** Previous psychiatric hospitalizations (Approximate dates and reasons):**

*** Have you ever talked with a psychiatrist, psychologist, or other mental health professionals? (If yes, please list approximate dates and reasons):**

*** Sexual & Gender Identity:**

- ☐ Heterosexual
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Transgender
- ☐ Asexual
- ☐ In Question
- ☐ Other

*** Racial/Ethnic Identity:**

- ☐ African/African-American/Black
 - ☐ American Indian/Alaska Native
 - ☐ Asian/Asian-American/Asian Pacific Islander
 - ☐ Bi-Racial/Multi-Racial
 - ☐ Latino/Latino-American
 - ☐ Middle Eastern/Middle Eastern-American
 - ☐ White/European-American
 - ☐ Not Listed
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Family:

* Rate and describe the current relationship with your mother (Rate 1-10 with 1 being poor and 10 being excellent):

* Rate and describe the current relationship with your father (rate 1-10 with 1 being poor and 10 being excellent):

* Are your parents still married or did they divorced?

* If divorced, how old were you when your parents separated or divorced and how do you think this impacted you?

* Please describe the relationship with your grandparents?

*** Were there any other primary care givers who have had a significant relationship in your life? If so, please describe how these people may have impacted your life:**

*** How many sisters do you have?**

*** Ages?**

*** Names:**

*** How many brothers do you have?**

*** Ages?**

*** Names:**

*** How would you describe the relationship with your siblings?**

Social Support, Self-care, & Education:

*** Your current level of satisfaction with friends and social support: (Rate 1-10 with 1 being poor and 10 being excellent):**

*** How would you describe the relationships with your peers?**

*** Please briefly describe any history of abuse, neglect and/or trauma:**

*** Please briefly describe your self-care and coping skills:**

*** What is your current diet, weight, and exercise/activity patterns?**

*** Please briefly describe your work performance and experience:**

*** Your current level of satisfaction with employment/position (Rate 1-10 with 1 being poor and 10 being excellent):**

*** What are your hobbies, talents, and strengths?**

*** Difficulty with:**

- ☐ Anxiety
- ☐ Depression
- ☐ Mood Changes
- ☐ Anger or Temper
- ☐ Panic
- ☐ Fears
- ☐ Irritability
- ☐ Concentration
- ☐ Headaches
- ☐ Loss of Memory
- ☐ Excessive Worry
- ☐ Wetting the Bed
- ☐ Trusting Others
- ☐ Communicating with Others
- ☐ Separation Anxiety
- ☐ Alcohol/Drugs
- ☐ Drinks Caffeine
- ☐ Frequent Vomiting
- ☐ Eating Problems
- ☐ Severe Weight Gain
- ☐ Severe Weight Loss
- ☐ Head Injury

*** Difficulty with:**

- ☐ Tantrums
- ☐ Parents Divorced
- ☐ Seizures
- ☐ Cries Easily
- ☐ Problems with Friend(s)
- ☐ Problems in School
- ☐ Fear of Strangers
- ☐ Fighting with Siblings
- ☐ Issues Re: Divorce
- ☐ Sexually Acting Out
- ☐ History of Child Abuse
- ☐ History of Sexual Abuse
- ☐ Domestic Violence
- ☐ Thoughts of Hurting Someone Else
- ☐ Hurting Self
- ☐ Thoughts of Suicide
- ☐ Sleeping Too Much
- ☐ Sleeping Too Little
- ☐ Getting to Sleep
- ☐ Waking Too Early
- ☐ Nightmares
- ☐ Sleeping Alone

*** Difficulty with:**

- ☐ Nausea
- ☐ Stomach Aches
- ☐ Fainting
- ☐ Dizziness
- ☐ Diarrhea
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Lump in the Throat
- ☐ Sweating
- ☐ Heart Problems
- ☐ Muscle Tension
- ☐ Bruises Easily
- ☐ Allergies
- ☐ Often Makes Careless Mistakes
- ☐ Fidgets Frequently
- ☐ Impulsive
- ☐ Waiting His/Her Turn
- ☐ Completing Tasks
- ☐ Paying Attention
- ☐ Easily Distracted by Noises
- ☐ Hyperactivity
- ☐ Chills or Hot Flashes

*** Family History of (Check all that apply):**

- ☐ Legal Trouble
- ☐ Drug/Alcohol Problems
- ☐ Domestic Violence
- ☐ Suicide
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Hyperactivity
- ☐ Learning Disabilities
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric Hospitalization
- ☐ "Nervous Breakdown"

*** Any additional information you would like to include:**


