Child Intake Form

Client Data:

Child's name: _____ Birth Date: _____

Age: _____ Gender: Male ◯ Female ◯

Person Completing Form: _____ Relationship to child: _____

Who referred you here? _____

Is English your preferred language? Yes ◯ No ◯ Is English your child' preferred language? Yes ◯ No ◯

If answered NO to either question: What is the preferred language of your child? _____

Describe any needs related to your culture or faith that might help us with your child's therapy:

_____

Child's school: _____ Grade: _____

Contact Information:

Please understand we will use the address listed below for all communication we mail to your home, including billing statements. If you would like to make alternative arrangements with us regarding your mailing address, please do not hesitate to let your therapist know.

_____

Address

_____ _____ _____

City State Zip Code

Contact Methods	Primary	Secondary	Can we leave a message here?
Cell Phone			Yes ◯ No ◯
Home Phone			Yes ◯ No ◯
Work Phone			Yes ◯ No ◯
Email Address			

Insurance and Billing Information:

Primary Insurance Carrier

Insurance Carrier (ex. BCBS):	
Is your primary insurance through MA or MHCP (Minnesota Healthcare Programs): Y ◯ N ◯	
Is your primary insurance through an employer? Y ◯ N ◯	
ID Number:	Group Number:
Name of Policy Holder:	
Address of Policy Holder:	
City, State, Zip of Policy Holder:	
Date of Birth of Policy Holder:	
Social Security Number of Policy Holder:	
Policy Holder's Relationship to the Client (ex. self, spouse, parent):	

Secondary Insurance Carrier:

Insurance Carrier (ex. BCBS):	
Is your primary insurance through MA or MHCP (Minnesota Healthcare Programs): Y ◯ N ◯	
Is your primary insurance through an employer? Y ◯ N ◯	
ID Number:	Group Number:
Name of Policy Holder:	
Address of Policy Holder:	
City, State, Zip of Policy Holder:	
Date of Birth of Policy Holder:	
Social Security Number of Policy Holder:	
Policy Holder's Relationship to the Client (ex. self, spouse, parent):	

Financial Guarantor (person responsible for payment)

The financial guarantor for an account is the person responsible for paying the bill. In most cases, this will be the client him/herself. If so, please fill in your own information. In other cases, someone else may be responsible. In that event, please fill in that person's information and have him/her sign below.

Name of Guarantor:	Date of Birth:
Address of Guarantor:	
City, State, Zip of Guarantor:	
Guarantor's Relationship to the Client (ex. self, spouse, parent):	

I understand I am solely responsible for any charges outstanding on the above client's account and accept responsibility for prompt payment of any outstanding balance: ☐

Presenting Problem

Briefly describe your child's current difficulties:

What have you done to try and resolve your concerns? Who have you talked to about these concerns?

How long has this (these) problem(s) been a concern?
When was the problem first noticed? By whom?
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 so, when and with whom?
Please describe any stressors that may be affecting your child today (divorce, relationship changes, unemployment, school, peers, losses, etc.). Note any changes in your child's mood or behaviors:

How are these concerns affecting you and your family

Please describe your child's strengths:

NOTES: (additional space for concerns)

Marital status of parents: Married ◯ Separated ◯ Divorced ◯ Never married ◯ Remarried ◯

Family & Social History

Mother's name: Age: Education:
Occupation: Work: Part-time ◯ Full-time ◯
Father's name: Age: Education:
Occupation: Work: Part-time ◯ Full-time ◯
Stepparent's name: Age: Education:
Occupation: Work: Part-time ◯ Full-time ◯
Stepparent's name: Age: Education:
Occupation: Work: Part-time ◯ Full-time ◯
If separated or divorced, what age was the child at the time of separation?

List all people living in the household:

Name:	Age:	Relationship to Child:

Any siblings not at home? (If so, please list with ages):
Is your child living with someone other than birth or adoptive parents? Yes ◯ No ◯
If yes, list legal guardians: Phone:
If parents are not legal guardians please submit documents regarding legal custody arrangements.
Is your child having relationship problems with family members? Yes ◯ No ◯
If yes, please explain:

Has your child ever been involved in the legal system (probation, truancy, child protections, etc.) Yes ◯ No ◯
If yes, please explain:

Probation Officer: Social Worker:

Developmental History

Were there any complications during labor, delivery or at birth? (cord around neck, stuck in birth canal, NICU, etc.).
Yes ◯ No ◯
If yes, please explain:

Were there any complications during pregnancy? (mom's chemical use, nutrition, illness, etc.). Yes ◯ No ◯
If yes, please explain:

Has your child ever had any illnesses, medical problems/procedures or injuries? (broken bones, surgeries, head injuries, etc.).
Yes ◯ No ◯
If yes, please explain:

Please note any major delays your child may have had: (Check all that apply)

- ☐ Speech. Age at which skill was developed:
- ☐ Sitting, Crawling, Walking. Age at which skill was developed
- ☐ Toilet Training. Age at which skill was developed:
- ☐ Sleeping through the night. Age at which skill was developed:

Has your child ever been separated from either parent for a period of time? Yes ◯ No ◯
If so, please explain:

Has your child had problems separating from parents or primary caregivers? Yes ◯ No ◯
If so, please explain:

Has your child ever had significant trauma? (Anything may be traumatic to a child and not to an adult. This can include falls off bikes, assault, bullying, discrimination, bodily harm, etc.). Yes ◯ No ◯
If so, please explain:

Has your child ever had significant loss? (death, divorce, moving, new school, loss of a pet, etc.). Yes ◯ No ◯
If so, please explain:

Are you concerned that your child is being-or has been-abused (sexually, physically or emotionally)? Yes ◯ No ◯
If so, please explain:

Has your child ever had nightmares, problems falling asleep or trouble sleeping through the night? Yes ◯ No ◯
If so, please explain:

NOTES: (Additional space for developmental history):

Educational History

Name of school: _____ Grade: _____

Place a check next to any educational problem that your child currently exhibits:

Reading: ☐ Math: ☐ Spelling: ☐ Writing: ☐ Speech: ☐ Hearing: ☐
Concentration/Focus: ☐ Attention: ☐ Other: _____ None: ☐

Is your child in a special education class? Yes ◯ No ◯
If yes, what type of class? _____
Has your child been held back in a grade? Yes ◯ No ◯
If yes, what grade and why? _____

Child's grades before this year: Low (D, F) ☐ Average (C) ☐ Above Average (A, B) ☐

Child's grades this year: Low (D, F) ☐ Average (C) ☐ Above Average (A, B) ☐

Has your child been diagnosed with ADD or ADHD? Yes: ◯ No: ◯
Does your child get along with peers? Younger: ☐ Near own age: ☐ Older: ☐ Does not get along with others: ☐

Has your child ever received therapy/counseling in school? Yes: ◯ No: ◯
If yes please describe: _____

Medical Information

Does your child have a primary care clinic or doctor? Yes: ◯ No: ◯
Name of clinic or doctor:
Phone: Date of last doctor's visit:

Does your child have a psychiatrist? Yes: ◯ No: ◯
Name of clinic or doctor:
Phone: Date of last doctor's visit:
Have you discussed mental health concerns with your child's primary care doctor? Yes: ◯ No: ◯
Does your child have any major medical problems? (chronic illness, seizures, etc) Yes: ◯ No: ◯
If so, please explain:

Does your child have problems with acute or chronic pain? Yes: ◯ No: ◯
If so, please explain:

Is your child taking any medications (prescribed, over-the-counter) or herbal products? Yes: ◯ No: ◯

Current Medications (include prescribed, over-the-counter and herbal medicines)

Medicine Name	Dose/How Often	Reason	Doctor who prescribed it

Has your child ever had any allergies or reactions to medicines? Yes: ◯ No: ◯
If so, please explain:

Place a check next to any illness or condition that your child has had. When you check an item, also note the approximate date or age of the illness.

Check		Age/date	Check		Age/date	Check		Age/date
☐	Measles:		☐	Dizziness:		☐	German measles:	
☐	Mumps:		☐	Chicken pox:		☐	Frequent/severe headaches:	
☐	Whooping cough:		☐	Diphtheria:		☐	Scarlet fever:	
☐	Meningitis:		☐	Encephalitis:		☐	High fever:	
☐	Convulsions:		☐	Allergy:		☐	Hay fever:	
☐	Head injuries:		☐	Broken bones:		☐	Hospitalizations:	
☐	Operations:		☐	Anemia:		☐	Difficulty concentrating:	
☐	Memory problems:		☐	Epilepsy:		☐	Extreme tiredness or weakness:	
☐	Rheumatic fever:		☐	Tuberculosis:		☐	Bone or joint disease:	
☐	Diabetes:		☐	Cancer:		☐	Gonorrhea or syphilis:	

- [ ] Jaundice/hepatitis: ☐
- [ ] Heart disease: ☐
- [ ] Suicide attempt: ☐
- [ ] Paralysis: ☐
- [ ] Asthma: ☐
- [ ] Bleeding problems: ☐
- [ ] Visual problems: ☐
- [ ] Loss of consciousness: ☐
- [ ] High blood pressure: ☐
- [ ] Eczema or hives: ☐
- [ ] Fainting spells: ☐
- [ ] Ear problems: ☐

Other (please describe and give age): ☐

Family Medical History

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

- [ ] Alcoholism: ☐ Relation to child
- [ ] Cancer: ☐
- [ ] Diabetes: ☐
- [ ] Heart trouble: ☐
- [ ] Drug addiction: ☐ Relation to child
- [ ] Depression: ☐
- [ ] Suicide attempt: ☐
- [ ] Nervous or psychological problem: ☐

Other ☐

Social and Behavior Checklist

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

- [ ] Speech
- [ ] Language
- [ ] Nightmares
- [ ] Is shy or timid
- [ ] Fights with siblings
- [ ] Troubles sleeping
- [ ] Is stubborn
- [ ] Is clumsy
- [ ] Slow learner
- [ ] Hearing
- [ ] Coordination
- [ ] Prefers to be alone
- [ ] Wets bed
- [ ] Bangs head
- [ ] Holds breath
- [ ] Over active
- [ ] Has blank spells
- [ ] Gives up easily
- [ ] Vision
- [ ] Is Aggressive
- [ ] Rocks back and forth
- [ ] Sucks thumb/finger
- [ ] Frequent tantrums
- [ ] Eats poorly
- [ ] Poor bowel control (soils self)
- [ ] Is Impulsive
- [ ] Daredevil behavior
- [ ] Agitated by noises/sounds
- [ ] More interested in things (objects) than in people
- [ ] Dangerous behavior to self or others (describe): ☐
- [ ] Has special fears, habits, or mannerisms (describe): ☐

Other information

What are your child's favorite activities?

1. ☐
2. ☐
3. ☐
4. ☐

Are there any guns in the home? Yes: ◯ No: ◯
If yes, are they locked in a secure place? Yes: ◯ No: ◯

What disciplinary techniques do you usually use when your child behaves inappropriately?

- [ ] Ignore problem behavior
- [ ] Scold child
- [ ] Spank child
- [ ] Threaten child
- [ ] Reason with child
- [ ] Redirect child's interest
- [ ] Tell child to sit on chair
- [ ] Send child to his or her room
- [ ] Take away some activity or food
- [ ] Don't use any technique
- [ ] Other techniques (describe): ☐

Which disciplinary techniques are usually effective?:
With what type of problem(s)?:
Which disciplinary techniques are usually ineffective?:
With what type of problem(s)?:
Is there anything else that you would like your child's therapist to know?:

Current Symptoms

Over the past 2 weeks, how often has your child had problems with the following?

Click drop down boxes to select level of severity

Symptoms	Not at all	Several Days	More than half the days	Nearly Everyday	Therapist's Notes	Onset	1=Mild 2=Moderate 3=Severe
Feeling sad	○	○	○	○			-
Crying without knowing why	○	○	○	○			-
Problems concentrating	○	○	○	○			-
Sleeping more or less than normal	○	○	○	○			-
Wanting to eat more or less than normal	○	○	○	○			-
Seeming withdrawn or isolated	○	○	○	○			-
Low self-esteem, poor self-image	○	○	○	○			-
Worry	○	○	○	○			-
Fears or phobias	○	○	○	○			-
Nightmares	○	○	○	○			-
Startles more easily	○	○	○	○			-
Avoids people, situations	○	○	○	○			-
Irritable and angry	○	○	○	○			-
Strives to be perfect	○	○	○	○			-

Behaviors	Not at all	Several Days	More than half the days	Nearly Everyday	Therapist's Notes	Onset	1=Mild 2=Moderate 3=Severe
Hyperactive	○	○	○	○			-
Tells lies	○	○	○	○			-
Defiant	○	○	○	○			-
Aggressive	○	○	○	○			-
Shoplifts or steals	○	○	○	○			-
Sets fires	○	○	○	○			-

Problems with attention or focus	◯	◯	◯	◯			-
Stays up all night	◯	◯	◯	◯			-
Acts out sexually	◯	◯	◯	◯			-
Gets into fights	◯	◯	◯	◯			-
Cruel to animals	◯	◯	◯	◯			-
Compulsively checks things, washes hands or puts things in order	◯	◯	◯	◯			-
Too much TV, Internet or computer games	◯	◯	◯	◯			-
Relationship problems with parents	◯	◯	◯	◯			-
Relationship problems with peers	◯	◯	◯	◯			-
Relationship problems with siblings	◯	◯	◯	◯			-
Recent grief	◯	◯	◯	◯			-
Other:	◯	◯	◯	◯			-
Other:	◯	◯	◯	◯			-
Other:	◯	◯	◯	◯			-
Other:	◯	◯	◯	◯			-

How many hours per week does your child spend doing the following:

Internet use: ☐ Computer or video games: ☐ TV: ☐

ACE Questionnaire:

To be filled out in reference to the child

Question 1: Before your 18th birthday, did a parent or other adult in the household often or very often… swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?
Yes: ◯ No: ◯

Question 2: Before your 18th birthday, did a parent or other adult in the household often or very often… push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?
Yes: ◯ No: ◯

Question 3: Before your 18th birthday, did an adult or person at least five years older than you ever… touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?
Yes: ◯ No: ◯

Question 4: Before your eighteenth birthday, did you often or very often feel that… no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?
Yes: ◯ No: ◯

Question 5: Before your 18th birthday, did you often or very often feel that… you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes: ◯ No: ◯

Question 6: Before your 18th birthday, was a biological parent ever lost to you through divorce, abandonment, or other reason?
Yes: ◯ No: ◯

Question 7: Before your 18th birthday, was your mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes: ◯ No: ◯

Question 8: Before your 18th birthday, did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
Yes: ◯ No: ◯

Question 9: Before your 18th birthday, was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes: ◯ No: ◯

Question 10: Before your 18th birthday, did a household member go to prison?
Yes: ◯ No: ◯

Total of questions answered "Yes:" [ ]

Family Life:

Please explain the typical mealtime routine for your family. (e.g. eating separately, all around the table, tense, quiet, loud, etc.):

Please explain how your family has fun together and what that looks like. (e.g. watching movies, going to the park, board games, once a week, never, etc.):

Please explain your family's rules, chores, and how you discipline. (e.g. only G-rated movies, no swearing, homework before play, washing the dishes, cleaning their room, spanking, time-outs, etc.):

Please explain your child's typical bedtime routine. (e.g. bedtime by 8pm, no phones allowed at night, reading to the child before bed, etc.):

Please explain how your family handles conflict. (e.g. yelling, quiet treatment, crying, all together, etc.):

Thank you for all your time and answers!