-Office Use Only-
Dx Code: _____
Intake Date: _____

Child Intake Form

Child's name: Date of Birth:
Child's School: Teacher: Grade:
Mother's name: Date of Birth: Occupation:
Father's name: Date of Birth: Occupation:

List all those living in the child's home:
Name: Relationship: Age/School/Occupation

List other persons closely involved in child's life but not living in the home:

What are your concerns about your child that made you bring him/her to therapy?

Please describe any concerns that are listed below that your child is displaying:
Difficulty sleeping/frequent nightmares :
Bed-wetting or soiling:
Unusually clingy or immature behavior:
Excessive fears, anxiety:
Physical complaints (stomachaches, headaches):
Change in eating habits:
Little sense of joy/happiness:
Hurts self on purpose/talks of wanting to die:
Blatant misbehavior:
Aggression towards others:
Hurts animals on purpose:
Sets fires:
Lies/steals:
Hides food:
School difficulties:
Difficulties with peers or bullying:
Inappropriate sexual behavior:
Poor self-esteem:
Overwhelming sadness:
Overwhelming anxiety or worry:

Please describe any other concerns you have about your child?

What are your child's strengths?

What are your child's interests and/or participation in after school activities?

Describe your child's school experience:

Does your child have an IEP or any other behavioral modifications strategies currently in place at school:

Describe your child's relationship with his/her siblings:

List any complications at birth and delays in development or difficulties when child was an infant/toddler:

List any ongoing health concerns/allergies your child has:

List any medications your child is taking and describe for what purpose:

Describe any serious difficulties or life stresses child has experienced and when they occured: _____

_____

_____

_____

_____

Describe your child's ability to complete tasks and follow directions: _____

_____

_____

_____

Who referred you for treatment? (teacher, school counselor, pediatrician, or other professional) _____

Describe any prior assessment/therapy child has received (name of professional, date of services, diagnosis): _____

_____

_____

Family Mental Health history: The following is to provide information about your family history. Please mark yes or no. If yes, please indicate family member affected.

Autism Spectrum	Yes	No	_____
Attention Deficit	Yes	No	_____
Depression	Yes	No	_____
Anxiety Disorder	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____