

CHILD INTAKE FORM- PARENT

Please fill out this form as completely as possible. The information will help me in our work together and it will make our first session together much more productive. If you do not desire to answer any question, write, "Prefer not to answer."

CLIENT NAME: _____ DATE: _____

GENDER: Male ____ Female ____

DATE OF BIRTH and PLACE OF BIRTH: _____ AGE: ____

ADDRESS: _____

CONTACT PERSON _____ RELATIONSHIP _____

TELEPHONE: H: _____ Cell: _____ Work/Off: _____

E-MAIL: _____

NUMBER WHERE I CAN LEAVE CONFIDENTIAL VOICEMAIL: _____

EMERGENCY CONTACT: _____ TELEPHONE: _____

RELEVANT HISTORY

Father's name _____ Date of birth _____ Occupation _____

Highest grade/Degree: _____ Type of degree: _____

Mother's name _____ Date of birth _____ Occupation _____

Highest grade/Degree: _____ Type of degree: _____

Marital Status: Married Separated (Since____) Divorced (Since____)

Name of other primary caretaker _____ Relationship _____

Language spoken at home _____

Was your child adopted? At what age? _____

How many siblings does the child have?

| Name | Age/Date of birth | Gender |
|------|-------------------|--------|
| 1. | | |
| 2. | | |
| 3. | | |

4.

Please list everyone who lives in the house with your child, including pets (what is their relationship to your child?): _____

PRENATAL HISTORY: Normal Abnormal

(specify) _____

DEVELOPMENTAL HISTORY

In brief, describe the child's sleeping habits _____

In brief, describe the child's eating habits _____

When did the child begin to walk? _____

When did the child begin to talk? _____

At what age was the child toilet trained? (months) _____

CURRENT SITUATIONS

WHY ARE YOU AND YOUR CHILD SEEKING HELP? (Be as specific as you can: when did the concern start? How does it affect you/your child?):

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ____ Very severe ____

What gives your child the most joy or pleasure in life?

What are your child's main worries and fears?

LIFESTYLE

Exercise. Please describe your child's activity level, forms of exercise and number of times per week:

Diet: Describe your child's diet and whether you consider it to be healthy for him/her:

Estimate how many hours/day your son/daughter spends online (Facebook, YouTube, internet gaming, texting, browsing, etc.):

Facebook/Instagram: ____ YouTube: ____ Gaming: ____ Texting: ____ Browsing: ____

Work/School: ____ Other: ____

Do you feel your child's technology use is balanced and healthy or could it use improvement? Please Explain: _____

Are you or your child involved in any current or pending civil or criminal litigation/s, lawsuit/s or divorce or custody dispute/s? (if you answer Yes, please explain): _____

MEDICAL AND TREATMENT HISTORY

Serious medical conditions: No. Yes.

(Specify) _____

Any food or drug allergies: No. Yes.

(Specify) _____

Past surgery(ies): No. Yes.

(Specify) _____

Past hospitalization(s): No. Yes.

(Specify) _____

STEPWELL MENTAL HEALTH & WELLNESS, PC

Does the child take medication? _____ If so, note prescriber _____

Current medications: _____

Any side effects: _____

Medication Compliance: Yes. No. Inconsistent.

Family History of Psychiatric Illness: _____

Any major events resulting in significant stress to the child?: _____

Has your child ever been diagnosed with a mental health disorder, behavioral problem or learning disability? Please specify: _____

Has your child ever attempted suicide? If so, please describe the circumstances, including ages, reasons, how, etc.: _____

Has your child been to therapy before? No. Yes.

If yes, in brief please provide your experience and reasons for the service _____

EDUCATIONAL HISTORY

Name of School

Date Attended

STEPWELL MENTAL HEALTH & WELLNESS, PC

Is a child on IEP plan?

Yes. (Since _____)

No.

What are your child's strengths? _____

Do you have any concerns regarding your child's learning style? _____

Do you have any concerns regarding your child's social development? _____

Has your child ever had any testing done?

No.

Yes. When/By Whom _____

WHO REFERRED YOU?

___ Google

___ Psychology Today

___ Theravive

___ Other web search

___ Referred by an individual: Please provide their name: _____

___ Other: Please list: _____

Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.