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CHILD INTAKE ASSESSMENT FORM

IDENTIFYING INFORMATION **Today's date: ______________________**

Child's name: ___________________________________ Age: _______ Grade: _________

Date of birth: _____________________ Race/ethnicity: ___________________________

Religious affiliation: _____________________ Social security number: _________________

Person(s) completing this form: ____

Child's custodian/guardian(s) is/are: ____

Child's Home Address: ____

City _________________________________ State ___________ Zip Code______________

Home Phone: _____________________ Other Phone (specify type): ____________________

Is it OK to contact you/child at home? yes no OK to leave a message? yes no

Special calling instructions? ____

Emergency Contact: ____________________________ Relationship to Child: _____________

Address: ____

City _____________________________ State _______________ Zip Code _______________

Home Telephone: _____________________ Other Phone (specify type): _________________

MOTHER'S INFORMATION

Mother's name: ________________________________ Date of birth: _______________

Phone: ___________________ Home Address: _____________________________________

City __________________________________ State ___________ Zip Code______________

Race/ethnicity: _____________________________ Religious affiliation: __________________

Highest Grade Completed: ______________________

Marital/relationship status (Check one): Married Live with partner Single

Widowed Separated/Divorced or Other: ______________________

Employment status (Check all that apply): Employed retired disabled

student homemaker unemployed

If/When employed, what type of work does mother do?

____

Current employer is: ____

Years on Current Job: _______________ Business Phone: ___________________________

Is it OK to contact mom at work? yes no OK to leave a message? yes no

Special calling instructions? ____

FATHER'S INFORMATION

Father's name: ___________________________________ Date of birth: _______________

Phone: ___________________ Home Address: _____________________________________

City __________________________________ State ___________ Zip Code______________

Race/ethnicity: _____________________________ Religious affiliation: __________________

Highest Grade Completed: ______________________

Marital/relationship status (Check one): Married Live with partner Single

Widowed Separated/Divorced or Other: ______________________

Employment status (Check all that apply): Employed retired disabled

student homemaker unemployed

If/When employed, what type of work does dad do?

____

Current employer is: ____

Years on Current Job: ______________ Business Phone: _________________________

Is it OK to contact dad at work? yes no OK to leave a message? yes no

Special calling instructions? ____

STEP-PARENT'S OR FOSTER PARENT'S INFORMATION

Name: ______________________________ Date of birth: ______________

Phone: __________________ Home Address: ___________________________________

City _______________________________ State __________ Zip Code_____________

Race/ethnicity: ___________________________ Religious affiliation: _________________

Highest Grade Completed: ______________________

Marital/relationship status (Check one): Married Live with partner Single Widowed Separated/Divorced or Other: ______________________

Employment status (Check all that apply): Employed retired disabled student homemaker unemployed

If/When employed, what type of work does Step or Foster Parent do?

____

Current employer is: ____

Years on Current Job: ______________ Business Phone: ___________________________

Is it OK to contact Step or Foster Parent at work? yes no

OK to leave a message? yes no

Special calling instructions? ____

STEP-PARENT'S OR FOSTER PARENT'S INFORMATION

Name: ______________________________ Date of birth: ______________________

Phone: __________________ Home Address: ___________________________________

City ___________________________________ State ___________ Zip Code_______________

Race/ethnicity: ______________________________ Religious affiliation: ___________________

Highest Grade Completed: ______________________

Marital/relationship status (Check one): Married Live with partner Single

Widowed Separated/Divorced or Other: ______________________

Employment status (Check all that apply): Employed retired disabled

student homemaker unemployed

If/When employed, what type of work does Step or Foster Parent do?

____

Current employer is: ____

Years on Current Job: _______________ Business Phone: ____________________________

Is it OK to contact Step or Foster Parent at work? yes no

OK to leave a message? yes no

Special calling instructions? ____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems your child is experiencing:

____

____

____

What has happened to cause you to seek help NOW?

____

____

____

What do you hope to be able to do or achieve as a result of treatment?

____

____

____

What do you consider to be other stresses in your child's life?

____

____

____

HISTORY OF THE PROBLEM

When did your child first start experiencing the problem(s) that brought you to the clinic today?

____

____

How often does the problem occur? ____

____

____

How long does it last? ____

____

____

Does your child have any thoughts of harming him/herself? No Yes

Has your child ever attempted to harm him/herself? No Yes If yes, please explain:

____

____

____

Does your child have any thoughts of harming someone else? No Yes

Has your child ever attempted to harm someone else? No Yes

If yes, please explain:

____

____

____

Has your child ever had previous therapy/counseling of any kind? No Yes

If yes, when and for how long? ____

____

____

What concerns were addressed in therapy? _______________________________________

____

Was this experience helpful (please explain)? _____________________________________

____

Has your child ever been hospitalized for emotional/behavioral problems? No Yes

If yes, when/where was this:

____

____

____

Has your child been prescribed medications to control emotional/behavioral problems?

No Yes If yes, please list medications, when prescribed, and by whom:

____

____

____

To your knowledge, has your child experimented with alcohol/drugs? No Yes

Are you concerned that your child might have or be developing a problem with alcohol or drugs? No Yes If yes, please explain:

____

____

____

FAMILY

Has this child ever experienced any parental separations, divorces, or death? No Yes

If yes, when?

____

How old was the child at the time? ____________ Please describe the circumstances.

____

____

If parents are separated or divorced, who has custody of this child? _________________________

How often does the other parent see this child?

____ Weekly or more often ____ Once or twice a month ____ Few times a year ____ Never

Please list the age and sex for each sibling (including those deceased, and step-siblings): Age, Sex, Relationship to Child Living at home?

____

____

____

Other than any children already indicated above and parents, who else lives in the child's household? Please describe the relationship of this person to the child/family.

____

____

____

Has anyone in the child's family had treatment for emotional problems? No Yes

If yes, please briefly explain (who/when): ____

____

____

Has anyone in your family ever attempted or committed suicide? No Yes

If yes, please briefly explain (who/when):

____

____

____

____

FAMILY/SOCIAL HISTORY & HEALTH

Describe father's present health: ____

____

____

Describe mother's present health: ____

____

____

Have **any** family members had any of the following? If yes, please specify family member's relationship to this child. Include all extended family members up to three generations. **Please specify birth relationships, step parent relationships and/or foster/adopted relationships.**

Cancer______________________________

Severe head injury________________________

Cerebral palsy ___________________________

Tourette's syndrome _______________________

Sexual Abuse____________________________

Homosexuality____________________________

Food allergies____________________________

Diabetes__________________________________

Alcohol abuse ___________________________

Heart disease ___________________________

High blood pressure ____________________

Kidney disease ________________________

Behavior disorder _____________________

Migraine headaches ____________________

Depression ___________________________

Multiple sclerosis ______________________

Mental Illness ________________________

Physical disability _____________________

Drug usage ___________________________

Physical abuse ________________________

Mental retardation _____________________

Stroke _______________________________

Nervousness __________________________

Tuberculosis _________________________

Seizures/epilepsy ______________________

Alzheimer's disease ____________________

Reading problem ______________________

Other Learning Problem ________________

Speech/language problem _______________

Sickle cell anemia _____________________

Sleep Difficulties ______________________

Tics _________________________________

Bipolar Disorder _______________________

Anxiety ______________________________

Schizophrenia _______________________

Attention Deficit/Hyperactivity Disorder ____

Criminal Activity ____

Other significant health or emotional problem: ___________________________________

What kinds of stressful events has your child experienced recently? ____________________

____

____

____

What kinds of stressful events have family members experienced recently? _______________

____

____

Which family member has the best relationship with the patient?

____

CHILD'S EDUCATION

School (name, address) ____

City _______________________________ State __________ Zip Code____________

Grade: ________ Age: ________ Teacher: _________________________________

Approx. Grades: ____

____

Describe any difficulties or problems your child is having in school:

____

____

____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his/her age? If not, please explain.

____

____

How would you rate your child's overall level of intelligence?

_____Below Average _____Above Average _____Average

PEER RELATIONSHIPS

How does your child get along with others his/her age? Please describe any problems.

____

____

____

CHILD'S DEVELOPMENT

Pregnancy and Delivery

Was this a planned pregnancy? No Yes

Was the mother under a doctor's care? No Yes

Number of previous pregnancies: ________ No. of Miscarriages: ________ Describe any complications that occurred during the pregnancy: ____________________________________

____

What drugs/medications were used during the pregnancy? ______________________________

____

At this child's birth, what was the mother's age? _________ Father's age? __________

Length of pregnancy: ________weeks Birth weight: ______ lbs. ______ oz.

Length of labor: ___________________________

Child's condition at birth: ____

____

Mother's condition at birth: ____

____

Length of stay in hospital: Mother _____ days Child _____ days

Is this child adopted? No Yes If yes, please provide adoption history:

____

____

____

____

Was this child breast-fed or bottle-fed? No Yes If yes, when was she/he weaned?

_____ At what age was this child toilet trained? Days: ________ Nights: _________

Did bed-wetting occur after toilet training? No Yes

If yes, until what age:________ Did soiling occur after toilet training? No Yes

If yes, until what age: ___________ Describe sleep patterns or problems:

____

____

Language difficulties? No Yes If yes, describe:

____

____

____

Delays with child are walking? No Yes If yes, describe:

____

____

____

As a young child, did your child have problems getting along with others? No Yes

If yes, describe:

____

____

Where there other problems experienced during the child's first year? No Yes

If yes, describe:

____

____

Infancy-Toddlerhood

Were any of the following present during the first few years?

____did not enjoy cuddling ____was not calmed by being held

____difficult to comfort ____Colic

____excessive restlessness ____excessive irritability

____frequent head banging ____constantly into everything

Temperament: Please rate the following as appeared in infancy and toddlerhood

Activity Level: ____underactive ____average activity level ____overactive

Intensity: ____average ____feelings were often intense

Adaptability: ____resisted change ____adapted easily to change

Mood: ____often happy ____average range of moods ____often dissatisfied or irritable

Developmental Milestones

As best you can recall, list age of development, or check item at right:

	AGE	OR:	EARLY	NORMAL	LATE
Walked without assistance:	____		_______	_______	_______
Toilet trained daytime:	____		_______	_______	_______
Toilet trained nighttime:	____		_______	_______	_______
Spoke first words:	____		_______	_______	_______

Any speech/articulation problems? Yes ___ No

Please rate your child on the following skills:

	GOOD	AVERAGE	POOR
Walking	______	__________	______
Running	______	__________	______
Throwing	______	__________	______
Catching	______	__________	______
Shoelace Tying	______	__________	______
Writing	______	__________	______
Athletic Abilities	______	__________	______

CHILD'S MEDICAL CARE

Child's physician: ______________________________ Phone: __________________________

Address: ____

City ___________________________________ State ___________ Zip Code______________

How often does this child see a doctor? _________________ Date of last visit: _____________

Is this child currently on any medication? No Yes If yes, indicate type and reason:

____

____

Does your child have any history of the following (please check all that apply): surgeries

hospitalizations high fevers allergies serious accidents

seizures digestive disorder serious illness head injuries

loss of consciousness eye, ear, nose & throat problems

Please list details of any conditions you checked above, including any additional childhood illnesses and other medical conditions: Condition/hospitalizations, Age, Treated by whom? Outcome of treatment?

____

____

____

CHILD'S INTERESTS AND ACTIVITIES

Is this child involved in any extracurricular activities, such as school sports or music programs? Clubs or religious organizations? No Yes If yes, please describe:

____

____

____

Please describe your child's strengths and positive characteristics:

____

____

Other information you feel is important and were not asked about:

____

____

HOME BEHAVIOR AND MOOD

______frequently irritable or moody

______can't seem to enjoy doing anything

______sad spells

______crying spells

______acts like a driven motor

______poor or low motivation

______doesn't seem to learn from experiences

______argues with or rude to teachers

______low self-esteem (makes negative statements about self)

______has ever been sexually abused

______nervous, anxious

______frequent headaches

______frequent stomachaches

______easily bored

______frequent arguing at home

______fearfulness

______can't seem to concentrate

______drug/alcohol/tobacco use

______eats (too much) or (too little)

______has ever been physically abused

______has had thoughts of or made comments about suicide

______very disorganized (loses things, has very messy room)

______difficulty sleeping: ___goes to sleep very late ___hard to get up in the morning

___very restless sleep ___bad dreams or night terrors

______has had a panic attack (rapid heartbeat, sweaty palms, feeling something bad is about to happen)

Thank you for your time and effort in completing this form!

Michael Vaughn, MA, PLPC, RES

Living Waters: Counseling Consulting Coaching