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PARENT INTAKE

Today's Date: ________________

Please provide the following information and bring the completed form to the first appointment. This will greatly assist me in my work with your child. Thank you!

Child's Name: ___________________________________ Date of Birth: ___________________

Street, City, Zip: ____

Name of parent(s) or guardian(s) who have legal custody: __________________________________

Address, if different from above: ____

Your Contact Information:

Home Phone: _____________________________ OK to leave a message? ☐ Yes ☐ No

Parent Cell/Other Phone: ____________________ OK to leave a message? ☐ Yes ☐ No

Email: ____________________________________ May I email you? ☐ Yes ☐ No

* Please be aware that email might not be confidential.

Referred by: ____

Do you wish for me to coordinate with your child's other providers: ☐ Yes* ☐No

If Yes, whom? ____

* If you would like me to share your child's health information with anyone other than his/her custodial parents/legal guardians, I will provide you with a Release of Information that authorizes me to do so.

In case of emergency, please contact:

Name: __________________________________ Relationship: ____________________________

Street, City, Zip: ____ Phone: _______________

Signature of Parent/Legal Custodian: _____________________________ **Date:** _______________

Concerns & Goals:

Please describe briefly why you are seeking treatment for your child: ____________________________

____

____

What are the three biggest concerns you have for your child right now?

1) ____
2) ____
3) ____

What are your goals for your child's treatment? What changes would you like to see?

____

____

____

What are your child's personal strengths? ____

____

____

Medical History:

Current medical problems for your child: ____

____

Past medical problems, hospitalizations, and surgeries: ____

____

Current prescription medications (include any psychiatric methods, if applicable): _________________

____

Psychiatric History:

Is your child bothered by problems with sleep: ☐ Yes ☐ No

If yes, please describe ____

Is your child bothered by hearing or seeing things, or by voices? ☐ Yes ☐ No

If yes, please describe: ____

Does your child have difficulty with focusing on tasks or finishing things? ☐ Yes ☐ No

If yes, please describe: ____

Has your children received previous psychotherapy or counseling? ☐ Yes ☐ No

If yes, when was that and for what issues was he/she being seen? ______________________________

____

Has your child ever been hospitalized for mental health problems? ☐ Yes ☐ No

If yes, please describe what happened including dates and where: ______________________________

____

Do you have any current concerns about your child's safety, e.g., self-harm, suicidal thoughts or behaviors? ☐ Yes ☐ No

If yes, please describe: ____

Please indicate if there is a history of any of the following **in your child's biological family including parents**. If yes, describe the family member's relationship to your child (e.g., parent, sibling, maternal or paternal grandparent, maternal or paternal aunt/uncle, etc.).

Anxiety	☐ No	☐ Yes ________________________________
Depression	☐ No	☐ Yes ________________________________
Bipolar Disorder	☐ No	☐ Yes ________________________________
Alcohol/Substance Abuse	☐ No	☐ Yes ________________________________
Schizophrenia	☐ No	☐ Yes ________________________________
Eating Disorder	☐ No	☐ Yes ________________________________
Physical/Sexual Abuse	☐ No	☐ Yes ________________________________
Suicide	☐ No	☐ Yes ________________________________
Attention Deficit Disorder/ Hyperactivity	☐ No	☐ Yes ________________________________

Substance Use:

To your knowledge, has your child every tried alcohol or other drugs (including tobacco)?
☐ Yes ☐ No

Has your child ever been treated for alcohol or drug use/abuse? ☐ Yes ☐ No

If yes, for which substances? ____

Where were they treated and when? ____

____

Legal History:

Has your child ever been arrested? ☐ Yes ☐ No

If yes, please describe: ____

Does your child have any pending legal problems? ☐ Yes ☐ No

If yes, please describe: ____

Developmental History:

Was your child adopted? ☐ Yes ☐ No If yes, at what age? _______________

When your child was born were there any medical concerns during labor, delivery, or immediately after his/her birth? ☐ Yes ☐ No ☐ Uncertain

If yes, please describe: ____

Developmental milestones (sitting up, walking, talking, toilet training, etc.) were:

☐ On time ☐ Delayed ☐ Earlier than other children ☐ Not sure

Brothers and Sisters:

Name	Sex	Age	Living where?	Is your child close to him/her?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Mother:

Age: ______ Any health concerns? ☐ Yes ☐ No

If yes, please describe: ____

Occupation: ____

Use three (or more, if you like) adjectives *to* describe *mother's* relationship with child: _____________

____

Father:

Age: ______ Any health concerns? ☐ Yes ☐ No

If yes, please describe: ____

Occupation: ____

Use three (or more, if you like) adjectives *to* describe *father's* relationship with child: _____________

____

Trauma History:

To your knowledge, was your child ever physically, verbally or sexually abused? ☐ Yes ☐ No

If yes, please describe: ____

____

Has your child ever experienced the loss or death of a close loved one? ☐ Yes ☐ No

If yes, please describe: ____

Educational History:

What school does your child attend? ____

How are his/her grades? ____

Does your child have any identified learning disabilities? ☐ Yes ☐ No

If yes, please describe: ____

How does your child do socially at school? ____

____

What do your child's teachers say about him/her? ___________________________________

____

Recreation & Social:

What activities and hobbies does your child enjoy? __________________________________

____

What kind of exercise does your child get and how often? ____________________________

____

Have there been recent changes in the activity level and interests of your child? ☐ Yes ☐ No

If yes, please describe: ____

How often does your child visit with his or her friends? ______________________________

What do you think of your child's group of friends? __________________________________

____

Spirituality:

Does your family belong to a particular religion or spiritual group? ☐ Yes ☐ No

If so, please describe your child's participation in religious or spiritual activity: ________________

____

* * * *

Please feel free to add any other information that you believe may improve my ability to provide effective care for your child: ____

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____

Thank you very much for taking the time to share this information!