CHILD INTAKE EVALUATION

To be completed by parent

Child's Name: ____ Today's Date: ________________

Gender: M _____ F _____ Age: _____ Birth Date: ______________________________ Marital Status: _______

Custodial Parent(s) Name: ____

Home Address: ____ City, State, Zip: __________________

Telephone (s): ____________________ ____________________ __________________________
(home) Parent (cell/work) Parent (cell/work)

Email: ____

May we leave messages for you at home? Yes or No:_______ May we leave messages at work? Yes or No: ______

Grade in School: ____________ School:___________________________Phone:_______________________

Referred by: ____

Others living in the home: ____________________________, ____________________________________,
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

__________________________, __________________________, ______________________________
(name, birthdate, relationship to client) (name, birthdate, relationship to client) (name, birthdate, relationship to client)

Emergency Contact: ___________________________________ Phone: ____________________________

Insurance Information

Name of Insured: ____ Insured date of birth: _____________

Address of Insured Person: ____________________________________ City, State, Zip: _________________

Relationship of client to insured person: __________________________

Employer of insured person: ___________________________________

Insurance company: ____Phone: ____________________

Insurance company address: _________________________________ City, State, Zip: __________________

Insurance identification number: ______________________________ Group number: ___________________

Secondary insurance: _______________________________________ Phone: ___________________________

Name of secondary insured: __________________________________ Date of Birth: _____________________

Secondary company address: ________________________________ City, State, Zip: ___________________

Secondary Identification number: _____________________________ Group number: ___________________

PATIENT OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefit to the provider of services.

____ Date: ______________________

PRESENTING PROBLEMS

Describe the child's problem(s) that brought you here today:

Check any of the symptoms that the child has been having:			
Depression		Feeling hopeless	
Extreme sadness		Feeling tearful/crying spells	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight/appetite changes	
Problems getting along with family		Problems getting along with friends	
Doesn't seem to enjoy usual activities		Feeling of extreme happiness	
Trouble doing school work		Truancy	
Feeling stressed		Irritability	
Perfectionist		Expresses feelings of guilt	
Worries		Seems nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Tense/uptight	
Anger outbursts		Acting violently	
Running away		Harm to animals	
Has hurt or cut on themselves Running away		Fire setting	
Thoughts of killing self		Thoughts of killing others	

WHAT HAS BEEN DONE ABOUT THIS PROBLEM SO FAR?

Have you worked with the child's teacher or school counselor? **Yes** ☐ **No** ☐
If you have, please describe it below.

Name of Teacher or Counselor:	Date(s):

HAS THE CHILD BEEN IN COUNSELING BEFORE? **Yes** ☐ **No** ☐

If the child has been in counseling before, please describe it below. Start with most recent time first.

A. When was the counseling?	Date(s):
Who did you see?	Name:
Explain what happened:	
B. When was the counseling?	Date(s):
Who did you see?	Name:
Explain what happened:	

HAS THE CHILD BEEN PRESCRIBED ANY PSYCHIATRIC MEDICATIONS? **Yes** ☐ **No** ☐

If yes, please describe:	Date(s):

SUBSTANCE USE HISTORY (If Applicable) **CHECK HERE IF N/A** ☐

Does the child use tobacco (any form)?	Current	Past	No
Does the child use alcohol?	Current	Past	No
Does the child use caffeine(any form, including cola drinks)?	Current	Past	No
Does the child use recreational drugs?	Current	Past	No

MEDICAL INFORMATION

Has the child seen a doctor within the past year? Yes ☐ No ☐
What was that for?
Who is the child's doctor? Phone:
Is the child taking any kind of medicine (prescription or over-the-counter)? Yes ☐ No ☐
Please list any medications that the child is taking: Please list any major medical problems that the child has had such as chronic illness, serious illness, operations, injuries or trauma to the head, etc:
Does the child have allergies to anything? Yes ☐ No ☐
Please describe any allergy problems that he/she may have:
Does the child have problems with sleeping? Yes ☐ No ☐
Does the child have problems with eating? Yes ☐ No ☐
Does the child have problems with toileting? Yes ☐ No ☐
Describe the problem(s):
Has the child been affected by any issues such as witnessing violence, having accidents, experiencing loss or experiencing abuse (physical, sexual or emotional)? Yes ☐ No ☐ Please describe the relevant issue(s):

DEVELOPMENTAL HISTORY

Were there any problems with the pregnancy or the delivery of the child? Yes ☐ No ☐
Any problems with eating, sleeping or crying spells (colic, nightmares, etc.)? Yes ☐ No ☐
Did the child demonstrate any difficulties or delays in walking, talking, toilet training? Yes ☐ No ☐
Has there been any family crisis such as marital separation or divorce? Yes ☐ No ☐
Have there been any mental health problems in the family of origin? Yes ☐ No ☐
Have there been any substance use or abuse issues in the family? Yes ☐ No ☐
Briefly describe the child's relationship to parents:
Briefly describe the child's relationship to siblings?
Briefly describe the child's temperament?

SCHOOL HISTORY

When did the child start school?
Were there any problems when the child started school? Yes ☐ No ☐
What problems have come up during the school years?
What grades is the child getting?
How does the child get along with his or her teachers?
How does the child get along with his or her friends or peers in school?
What are the child's favorite subjects or school activities?
What subjects or activities does the child have problems with?

CHILD CHECKLIST OF CHARACTERISTICS

Please review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics".

- ☐ Affectionate
- ☐ Argues, "talks back", smart-alecky, defiant
- ☐ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- ☐ Cheats
- ☐ Cruel to animals
- ☐ Concern for others
- ☐ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- ☐ Complains
- ☐ Cries easily, feelings are easily hurt
- ☐ Dawdles, procrastinates, wastes time
- ☐ Difficulties with parent's paramour/new marriage/new family
- ☐ Dependent, immature
- ☐ Developmental delays
- ☐ Disrupts family activities
- ☐ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- ☐ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ☐ Dropping out of school
- ☐ Drug or alcohol use
- ☐ Eating – poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- ☐ Exercise problems
- ☐ Extracurricular activities interfere with academics
- ☐ Failure in school
- ☐ Fearful
- ☐ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ☐ Fire setting
- ☐ Friendly, outgoing, social
- ☐ Hypochondriac, always complains feeling sick
- ☐ Immature, "clowns around", has only younger playmates
- ☐ Imaginary playmates, fantasy
- ☐ Independent
- ☐ Interrupts, talks out, yells
- ☐ Lacks organization, unprepared
- ☐ Lacks respect for authority, insults, dares, provokes, manipulates
- ☐ Learning disability
- ☐ Legal difficulties – truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ☐ Likes to be alone, withdraws, isolates
- ☐ Lying
- ☐ Low frustration tolerance, irritability
- ☐ Mental retardation
- ☐ Moody
- ☐ Mute, refuses to speak
- ☐ Nail biting
- ☐ Nervous

- ☐ Nightmares
- ☐ Need for high degree of supervision at home over play/chores/schedule
- ☐ Obedient
- ☐ Obesity
- ☐ Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- ☐ Oppositional, resists, refuses, does not comply, negativism
- ☐ Prejudiced, bigoted, insulting, name calling, intolerant
- ☐ Pouts
- ☐ Recent move, new school, loss of friends
- ☐ Relationships with brothers/sisters or friends/peers are poor – competition, fights, teasing/provoking, assaults
- ☐ Responsible
- ☐ Rocking or other repetitive movements
- ☐ Runs away
- ☐ Sad, unhappy
- ☐ Self-harming behaviors – biting or hitting self, head banging, scratching self
- ☐ Speech difficulties
- ☐ Sexual – sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ☐ Shy, timid
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Swearing, blasphemes, bathroom language, foul language
- ☐ Temper tantrums, rages
- ☐ Thumb sucking, finger sucking, hair chewing
- ☐ Tics – involuntary rapid movements, noises, or work productions
- ☐ Teased, picked on, victimized, bullied
- ☐ Truant, school avoiding
- ☐ Underactive, slow-moving or slow-responding, lethargic
- ☐ Uncoordinated, accident-prone
- ☐ Wetting or soiling the bed or clothes
- ☐ Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics:

- ☐ ____
  ____
  ____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it? ______________________________
____
____
____

This is strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.