Capturing Hope Counseling

Child Intake Form

Date:_____

Personal Information

Child's Name: _____ DOB: _____ Sex: Male Female

Address: _____

Home#: _____ Cell#: _____ Work/School#: _____

Parent/Guardian Contact: _____ Parent/Guardian Email: _____

Home#: _____ Cell#: _____ Work#: _____

Who recommended you? _____

Reason child is coming for services: _____

Medical History

Please list any current medical problems: _____

Allergies: _____

Please list all prescription and over the counter medications you are taking:

Medication	Prescribing Doctor	Dosage/Frequency	Reason for Taking

Previous medical conditions: _____

List hospitalizations/surgeries:

Place	Date	Reason

Does the child use tobacco? Yes No Amount per day: _____

Does the child drink alcohol? Yes No Amount per day: _____

Does the child consume: caffeine candy soda pop

Has the child ever had an addiction problem? Yes No Describe: _____

How physically active is your child? hyper athletic normal couch potato

Other/Details: _____

Sleep Problems: falling asleep staying asleep nightmares waking early oversleeping

Hours of sleep daily: _____

Appetite: no appetite overeating binge eating purging/vomiting nausea
Do you consider your child to be: normal weight underweight overweight

Psychiatric History

Have you been to counseling before? Yes No

Professional Seen	Start Date	End Date	Reason Seen

Has child had recent thoughts about: not wanting to live hurting self hurting someone else
Has child ever: made a suicide attempt injured self on purpose overdosed on meds or drugs
Comments: _____

Childhood Developmental History

Birth weight: _____ Complications with pregnancy or birth? Yes No
Describe: _____

Any developmental problems? Yes No
Describe: _____

At what age was the child able to:

Sleep All Night: ____ Sit Up: ____ Crawl: ____ Stand: ____
Walk: ____ Dress Self: ____ Speak: ____ Speak Sentences: ____
Feed Self: ____ Begin Potty Training: ____ Complete Potty Training: ____

How would you describe child's temperament as an infant and young child?
easy difficult shy other/details: _____

Was the mother exposed to any medication, illnesses, alcohol or drugs during pregnancy?
Yes No Describe: _____

Family History

List relatives which have the following:

ADHD/ADD: _____ Alcohol/Drug Issues: _____
Anxiety: _____ Autism: _____
Bipolar Disorder: _____ Depression: _____
Mental Retardation: _____ Obsessions/Compulsions: _____
Panic Attacks: _____ Phobias: _____
Schizophrenia: _____ Seizures: _____

Was child adopted? Yes No If yes, at what age? _____
What does the child know? _____

	Name	Age/DOB	Highest Education	Occupation
Mother:				
Stepmother:				
Father:				
Stepfather:				

Describe child's relationship with parents:

Siblings and their ages:

Describe child's relationship with siblings:

Are child's parents: married separated divorced never married

If parents are not living together, how old was child when this occurred?

Who does the child live with? Who has custody?

How often does child see the other parent?

Are there conflicts over: custody visitation child support other:

Is either parent currently involved in a relationship? Yes No

If yes, describe relationship and child's reactions:

Has child ever lived outside parent's home for an extended time? Yes No

If yes, describe the situation:

List all people who live with child:

Name	Age/DOB	Relationship to Child

List siblings and parents who live out of the home:

Has the child ever been abused or neglected? Yes No Offender:

Type of abuse/neglect: physical emotional verbal sexual

Has the child been abusive to others? Yes No Offended:

Type of abuse: physical emotional verbal sexual

Describe any traumatic events child has witnessed:

Is the family experiencing problems of the following: legal financial marital

Describe: _____

Religious Beliefs/Practice

Does child believe in God or a higher power? _____

Does child attend religious services with the family? Yes No What religion? _____

How often? _____

Does child attend religious services with a friend? Yes No What religion? _____

How often? _____

Relationships

Is child able to make and keep friends? Yes No Sometimes

If not, why? _____

Are child's friends usually: same age older younger

Do you approve of child's friends? Yes No

If not, why? _____

Does child: pick on others get picked on want to be the boss have problems fitting in easily become physically aggressive keep to self dominate relationships

Is child dating? Yes No Is child sexually active? Yes No

School

Child's School: _____ Current Grade: _____

Teacher's Name: _____ Counselor's Name: _____

Describe child's attitude towards school: _____

Has child dropped out of school? Yes No When: _____

If yes, describe: _____

Does child experience problems in school with: reading spelling writing math attention behavior peer relationships teachers administrators

Describe: _____

Describe child's grades: _____

Has child ever: repeated a grade level skipped a grade level

Describe: _____

Has child received Special Education Services? Yes No

Describe: _____

List school activities child is involved with: _____

Work

Is child employed? Yes No Occupation: _____ Hours/Week: _____

How long has child had this job: _____

Describe any problems at work: _____

Describe previous work history: _____

Describe volunteer work history: _____

Other Information

What does child do with spare time:

What activities do you do with child:

List discipline methods used with child:

How does child respond to discipline:

List child's chores at home:

What are child's strengths:

What would you like to see child change:

What goals would you like to see accomplished through counseling:

List any additional information that you feel may be important or helpful: