

CHILD INTAKE FORM
(Please complete in Ink)

CHILD

1. Child's Name _____ Sex _____ Age _____ DOB _____
2. Natural Child Yes / No If adopted, at what age _____ Foster since _____
3. Parent's Names (include step-parents, foster parents, inc.)

4. Comments about custody and visitation (if applicable):

5. Primary reason you are concerned about your child?

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

- | | |
|--------------------------------------|--------------------------------------|
| a. _____ Sleep problems | _____ Morbid thoughts |
| _____ Lack of interest in activities | _____ Suicidal thoughts or threats |
| _____ Unassertive | _____ Suicidal plans / attempts |
| _____ Fatigue/low energy | _____ Mood swings |
| _____ Concentration problems | _____ Depression |
| _____ Appetite/weight changes | _____ Changed level of activity |
| _____ Withdrawal | _____ Cries easily |
| b. _____ Forgetful/memory problems | _____ Talks excessively / interrupts |
| _____ Short attention span | _____ Easily distracted |
| _____ Aggressive behavior | _____ Irritable |
| _____ Can't sit still | _____ Impulsive |
| _____ Not interested in peers | _____ Difficulty following rules |
| _____ Picked on / bullied by peers | _____ Problem completing schoolwork |

- | | |
|---|---|
| <p>c. <input type="checkbox"/> Excessive worry / fearfulness
 <input type="checkbox"/> Anxiety or panic attacks
 <input type="checkbox"/> Social fears, shyness
 <input type="checkbox"/> Separation problems
 <input type="checkbox"/> Bedwetting / soiling
 <input type="checkbox"/> Headaches, stomachaches
 <input type="checkbox"/> Odd beliefs / fantasizing</p> <p>d. <input type="checkbox"/> Lying
 <input type="checkbox"/> Trouble with the law
 <input type="checkbox"/> Running away
 <input type="checkbox"/> Truancy, skipping school
 <input type="checkbox"/> Hurting others sexually
 <input type="checkbox"/> Alcohol / drug use
 <input type="checkbox"/> Argumentative / defiant
 <input type="checkbox"/> Swears
 <input type="checkbox"/> Blames others for mistakes</p> | <p><input type="checkbox"/> Nightmares
 <input type="checkbox"/> Frequent tantrums
 <input type="checkbox"/> Resistive to change
 <input type="checkbox"/> School refusal
 <input type="checkbox"/> Perfectionism
 <input type="checkbox"/> Odd hand / motor movements
 <input type="checkbox"/> Hallucinations</p> <p><input type="checkbox"/> Stealing
 <input type="checkbox"/> Being destructive
 <input type="checkbox"/> Fire setting
 <input type="checkbox"/> Hurting others / fighting
 <input type="checkbox"/> Acts as if has no fear
 <input type="checkbox"/> Short tempered
 <input type="checkbox"/> Easily annoyed / annoys others
 <input type="checkbox"/> Discipline problem
 <input type="checkbox"/> Angry and resentful</p> |
|---|---|

Brothers and Sisters

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

SCHOOL HISTORY

- Present School: _____ Grade: ____ Teacher: _____
- Has child ever repeated any grade? _____
- Is child in special education services? No ____ Yes, what kind? _____
- Please describe academic or other problems your child has had in school

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. **Pregnancy**

Mother used during pregnancy: alcohol ____ drugs ____ cigarettes ____

Delivery: Normal ____ Breech ____ Cesarean ____ Transectional ____
 Full-term ____ Premature ____ if premature, number of weeks ____

Birth Weight: _____

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)

2. Developmental History

- State approximate age when child did the following:
Walked alone _____ Said first word _____ Used 2-word phrases _____
- Understood and followed simple directions _____
- Reasonably well toilet trained _____
- Did child cry excessively? _____ Rarely cried _____

3. Health History of Child

In the first two years, did your child experience: ___ Separation from mother,
___ Out of home care, ___ Disruption in bonding, ___ Depression of mother, ___ Abuse,
___ Neglect, ___ Chronic pain, ___ Chronic Illness, ___ Parental Stress

- Child's Doctor: _____
 - Date of last physical exam: _____
 - Vision problems? Yes _____ No _____ Hearing problems? Yes _____ No _____
 - Dental problems? Yes _____ No _____
 - Any head injuries or loss of consciousness? Yes _____ No _____
 - Child's history of serious illness, injury, handicaps, or hospitalization?
No _____ Yes – describe and give dates _____
 - Is your child currently taking any medications? No _____ Yes _____ name medications _____
-

- List any medicines previously used for emotional problems: were they helpful? _____

- Allergies to drugs or medicines? No _____ Yes _____ (list) _____
- Allergies to any foods? No _____ Yes _____ (list) _____
- Are there any foods that you limit or do not give this child? No _____ Yes _____
(list) _____.
- Allergies to environmental conditions? No _____ Yes _____ (list) _____
- Does anyone in the household smoke? No _____ Yes _____
- About how many hours does this child watch TV, videos, etc per day _____
- Are you afraid someone you know may injure/harm this child? No _____ Yes _____

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- Does this child have a Health Care Directive? No _____ Yes _____
If yes, please list where (clinic) it is on file _____
- Any previous psychological or psychiatric treatment? No _____ Yes _____
Whom/where _____ when _____
- Any previous testing (school/psychological)? No _____ Yes _____
Whom/where _____ when _____
- Do you think your child's use of chemicals is a problem? No _____ Yes _____
Type: Alcohol _____ Marijuana _____ Other drugs _____
Comments: _____

Family History:

Chemical use (now & past): No _____ Yes _____ Which parent _____
Type: Alcohol _____ Marijuana _____ Other drugs _____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

Has child witnessed domestic violence? __Y, __N, Specify: _____

How is your child disciplined? Please list each method and frequency of use: _____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? __Y, __N, __Suspected. Specify: _____

2. Has your child been physically abused? __Y, __N, __Suspected. Specify: _____

3. Has your child been sexually abused? __Y, __N, __Suspected. Specify: _____

4. Other stressors or traumas? _____

What are your child's strengths?

Any additional comments or information that would be helpful to us?

Signature of person completing form / relationship to client:

Name Relationship Date: _____

See IFCSF for annual review of medical status