CHILD INTAKE FORM

Please provide the following information about your child:

Child's Name: _____

Date of Birth: _____ Age: _____

Parent's Names: _____

Step-Parent(s) Names: _____

Child's Primary Address: _____

_____

Home # (mother) _____ May I leave a message ? Yes/No

Work # (mother) _____ May I leave a message? Yes/No

Mobile # (mother) _____ May I leave a message? Yes/No

Home # (father) _____ May I leave a message ? Yes/No

Work # (father) _____ May I leave a message? Yes/No

Mobile # (father) _____ May I leave a message? Yes/No

Email address (Note that email correspondence is not considered a confidential method of communication): _____

May I email you? Yes/No

Emergency contact name and number

_____

Referred by : _____

Education History

What school does your child attend?_____

Grade:_____

What does your child's teacher say about your child?

_____

_____

_____

Has your child ever repeated a grade? Yes/No If yes, which one(s):_____

If applicable to presenting problem, school guidance counsellor's name and number:

_____

Has your child ever received special education services?

_____

_____

_____

Has your child experienced any of the following at school? Please circle when applicable.

Fighting Suspension Gang Influence Lack of Friends Learning Disabilities

Drugs/Alcohol Detention Poor Grades Poor Attendance Peer Pressure

Behavioral Problems Incomplete Homework Anxiety Fear of Failure

Family History

The name of the child's biological parents

Mother:_____ Father:_____

Child's parents are:(circle one) Single/ Married/ Separated/ Divorced/ Widowed /Cohabiting

Who has legal guardianship of your child? _____

Who does your child currently live with?_____

*Please list all individuals who are currently living at the child's primary residence

Names	Ages	Relationship to the child

*If applicable, please list all individuals who are currently living at the child's secondary residence

Names	Ages	Relationship to the child

Have there been any deaths of or separations from parents, family members, nannies, babysitters or friends with whom your child was close or had frequent contact?

What are some of the things that are currently stressful to your child and your family?

Medical History

What is the name and number of your child's physician?

Please list any significant medical problems that your child has ever had.

Current Medications for Medical Issues

Rx Name: _____ Dosage: _____ mg _____ Start Date: / / / /

Rx Name: _____ Dosage: _____ mg _____ Start Date: / / / /

Did the child's mother have any problems during the pregnancy or at delivery? Yes/No. If yes, please describe them.

Did you have any concerns regarding your child's development from ages 0 to 5 years old?

Excessive crying: Y/N Hyperactivity: Y/N Speech: Y/N Vision: Y/N

Feeding problems: Y/N Sleep: Y/N Hearing: Y/N Social Relatedness: Y/N

If you answered yes, to any of the above, please describe:

Please provide any other important information about your child's development that you feel is important?

Has your child ever had psychological/psychiatric treatment of any kind? Yes/No.
If yes, please elaborate.

Is your child currently taking medication for a psychiatric problem Yes/No.
If yes, please list the name of his/her prescribing psychiatrist

If yes, please list the names, dosage and start dates of each of his/her medications:

Rx Name:_____ Dosage:_____mg Start Date:__/__/__/__/__

Rx Name:_____ Dosage:_____mg Start Date:__/__/__/__/__

Have any family members had emotional or psychiatric problems? Yes/No
If yes, please indicate who? What was the nature of their difficulties? And whether or not treatment was sought?

Reason for Referral

Please circle the issues or symptoms you are currently concerned about with respect to your child:

Sad/Depressed Mood Sleep Disturbances Hearing Voices Trauma

Worries/Anxiety Nightmares Seeing Things Others Don't See Withdrawn

Poor Attention/Concentration Inappropriate Sexual Behavior Repetitive Behaviors

Irritable Hyperactivity Shyness Physical Aggression/ Fighting

Academic Performance Social Skills Decreased/Increased Appetite

School Attendance Victim of Bullying Restrictive Eating/Binging/Purging

Oppositional/Defiant Towards Adults Conflict in Family Relationships Bereavement

Stealing/Lying Alcohol/Drug Use Self-Injurious Behavior (i.e cutting)

Wetting/Soiling Bed or Pants Parental Divorce/Separation Suicidal Thoughts

Please elaborate on the concerns circled above and describe why you are seeking treatment for your child.

When did these difficulties begin? Did any specific event occur prior to them beginning?

Does your child agree with your understanding of the presenting issue(s)? Yes/No
If no, please describe how your child views your current concerns.

Parent's Name and Signature: _____

Parent's Name and Signature: _____

Date: _____