

INTAKE FORM FOR PARENT AND CHILD

This intake form requires information on **BOTH** parent and child. Please read each section carefully to understand which section pertains to you and which selection pertains to your child.

CUSTODIAL PARENT/GUARDIAN INFORMATION (Who has legal custody of this child)	
___ Both Parents ___ Mother ___ Father ___ Other (complete info. in box)	
First Name: _____	MI: _____ Home PH: _____
Last Name: _____	Work PH: _____
Address: _____	DOB: ____ / ____ / ____
City: _____ State: _____ Zip: _____	___ Male ___ Female
Relation to Client: _____	

PARENT INFORMATION

Mother

First Name: _____ Last Name: _____

D.O.B. (mm/dd/yyyy) ____ / ____ / ____ SSN: ____ / ____ / ____

Address: _____ Home PH: _____

_____ Cell PH: _____

Occupation: _____ How Long: _____

Place of Employment: _____

Education (highest grade or degree completed): _____

Other Education or Training: _____

MARITAL STATUS: ___ Married ___ Single ___ Divorced ___ Widowed ___ Co-Habiting

If married: wedding date: ____ / ____ / ____ How many previous marriages? _____

If spouse is step-parent or if you are co-habiting:

Name: _____

Get along with client? ___ Yes ___ No

Father

First Name: _____ Last Name: _____

D.O.B. (mm/dd/yyyy) ____ / ____ / _____ SSN: ____ / ____ / ____

Address: _____ Home PH: _____

_____ Cell PH: _____

Occupation: _____ How Long: _____

Place of Employment: _____

Education (highest grade or degree completed): _____

Other Education or Training: _____

MARITAL STATUS: ____ Married ____ Single ____ Divorced ____ Widowed ____ Co-Habiting

If married: wedding date: ____ / ____ / _____ How many previous marriages? _____

If spouse is step-parent or if you are co-habiting:

Name: _____

Get along with client? ____ Yes ____ No

CHILD/CLIENT INFORMATION

First Name: _____ Last Name: _____

Gender: ____ Male ____ Female D.O.B. (mm/dd/yyyy): ____ / ____ / _____

School: _____ Grade: _____

Physician(s) of CHILD: _____

CHILD'S MEDICATIONS

Current Medications

Medication	Dosage	Frequency

Past Medications

Medication	Dosage	Frequency

List all persons living in the home with child:

Name	Age	Sex	Relationship to child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List other children not in the home:

Name	Age	Sex	Relationship to child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CHECK ANY OF THE BEHAVIORS THAT ARE TRUE FOR YOUR CHILD

Feelings: Does your child show feelings that concern you or seem strange for his/her age? YES NO

Check all that apply:

- _____ Is restless
- _____ Is sad or cries easily
- _____ Is overly guilty
- _____ Is irritable or angers easily
- _____ Is sullen
- _____ Lacks remorse
- _____ Is fearful
- _____ Is bored

Behaviors: does your child often do things that seem strange for their age? YES NO

Check all that apply

- Has problems in school
- Lacks interest in things he/she use to enjoy
- Plays sexual games with others, toys, animals (pertains to ages 3-9)
- Is involved in sexual activity (pertaining to ages 10-17)
- Destroys possessions or other property
- Steals
- Refuses to talk
- Sets fires
- Is overactive
- Hurts himself or herself
- Has been in trouble with police

Social Interactions: Do you have any concerns about how your child gets along with you? YES NO

With other family members or adults? YES NO

With playmates/peers? YES NO

Check all that apply

- Withdraws and does not look into people's eyes
- Clings to you too much
- Has a hard time making and keeping friends
- Is defiant, has disciplinary problems
- Severe and frequent tantrums
- Picks on others or often gets into fights
- Argues too much
- Will not go to school
- Prefers to be alone

Thinking: Do you have any concerns about your child's thinking processes? YES NO

Check all that apply

- Is frequently confused
- Daydreams often
- Is distracted, doesn't pay attention
- Has very strange thoughts

- Sees or hears things that are not there
- Blames others for his/her misdeeds
- Talks about death or suicide often
- Cannot remember things
- Does not trust others

Physical Problems: If you think your child may have health problems, has he/she seen a doctor or nurse about the problem? YES NO

Check all that apply

- Lacks energy
- Uses laxatives frequently
- Vomits often
- Will not eat
- Sneaks food
- Has stomach aches often
- Wets or soils pants
- Has headaches often
- Has lost or gained a significant amount of weight
- Has sleeping problems (nightmares, sleepwalking, early waking, frequently interrupted sleep)

Is your child accident prone? YES NO

Is anything causing your family stress right now? YES NO

If "YES" please briefly explain: _____

Has your child been the subject of neglect, physical, sexual, or emotional abuse? YES NO

If "YES" what form(s)? _____

Has treatment been initiated? YES NO

If "YES" with whom? _____

If "YES" is treatment still ongoing? YES NO

Has your child been treated for mental health problems or substance abuse? YES NO

How were you referred to this center? _____
