**New Client Intake Form**

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell # (caregiver #1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to leave a message? \_\_\_\_\_\_

Cell # (caregiver #2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to leave a message? \_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_

Email (caregiver #1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email (caregiver #2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Presenting Problems: |

|  |
| --- |
| Can you identify any event or experience that preceded these challenges? |

|  |
| --- |
| When did you first notice these symptoms (approximately? |

**Child’s Demographics**

Child’s full legal name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic Identification:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year in School:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teacher’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s current residence: (please check one) \_\_\_\_\_\_With biological parents

\_\_\_\_\_With Foster Parents \_\_\_\_\_\_With Adoptive Parents \_\_\_\_\_Other

If other, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Residential Parents’ Demographics**

Parent 1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic Identification:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic Identification:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other parents who child does not reside with:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has legal custody of the child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*\*custody paperwork clearly stating who has the right to consent for treatment must be presented before therapy with a minor child can begin\*\*\**

**Family/Home Information- Please list everyone who resides in your home full or part time**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Relationship to Child** | **Full or Part Time Home Member** | **Gender** |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Has the child lived with both parents since birth?   No   Yes

If no, please list changes chronologically (including all out-of-home placements, hospitalizations, or treatment):

|  |  |  |  |
| --- | --- | --- | --- |
| **From when:** | **To when:** | **Child lived with:** | **Reason for Move:** |
|  |  |  |  |
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|  |  |  |  |

If child is not living with both birth parents, please list all reasons:

Parents separated Parents divorced Parent deceased \_\_\_\_Other**\_\_\_** Child Adopted

If other, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the child has a parent not living with the child, are there visitations?

Yes How frequently:   No Reason:

**Does anyone else in the family:**

* Have a physical or emotional problem? \_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_\_\_ YES

If yes, explain:

* Ever received any counseling or taken medications for mental health treatment? \_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_\_\_ YES

If yes, explain:

* Have a history of being the perpetrator or victim of domestic violence?  \_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_\_\_ YES

If yes, explain:

* Have a history AT ANY TIME of struggling with drug or alcohol use, misuse, addiction, or treatment? \_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_\_\_ YES

If yes, explain:

**Child’s Development & Early History:**

|  |  |  |
| --- | --- | --- |
|  | **NO** | **YES** |
| Was this pregnancy planned? |  |  |
| Were there any prenatal problems? |  |  |
| Did the mother experience any unusual stress during pregnancy? |  |  |
| Was the fetus exposed to any drugs or alcohol? |  |  |
| Were their any problems with delivery? |  |  |
| Was this child born vaginally? |  |  |
| Did the child’s mother suffer postpartum depression or anxiety? |  |  |
| Was there any unusual stress in the year after birth? |  |  |
| Did the infant have feeding problems? |  |  |
| Did the infant sleep well? |  |  |
| Was the infant breastfed? |  |  |
| Was the infant separate from mother after birth, even briefly? |  |  |
| Did you child meet developmental milestones?Â |  |  |
| Has your child struggled with bedwetting/soiling (beyond developmentally appropriate?) |  |  |
| Has your child with daytime toileting accidents (beyond developmentally appropriate?) |  |  |
| Has you child experienced multiple ear infections? |  |  |
| Does your child have allergies? |  |  |
| Has your child ever been hospitalized or to the ER |  |  |
| Has your child ever had a head injury? |  |  |

**Would you describe your child in any of these ways during their first years?**

|  |  |  |
| --- | --- | --- |
|  | **NO** | **YES** |
| Did not enjoy cuddling |  |  |
| Difficult to comfort |  |  |
| Restless |  |  |
| Head Banging |  |  |
| Reflux |  |  |
| Not calmed by being held |  |  |
| Colic |  |  |
| Excessive irritability |  |  |
| Constantly into everything |  |  |
| Listless/Unresponsive |  |  |
| Overactive |  |  |
| Adapted easily to change |  |  |
| Intense feelings |  |  |

Name of child’s primary physician and phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications is your child currently taking?

|  |  |  |
| --- | --- | --- |
| Medication | Dose | For what |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**School**

|  |
| --- |
| Has your child ever had behavioral, emotional, or academic challenges at school, at any age?  If yes, please describe. |

**Counseling History:** Please include all psychotherapists, psychiatrists, psychologists, occupational therapists, equine therapists, neurofeedback, or any other types of therapy or treatment you have pursued for your child.

|  |  |  |  |
| --- | --- | --- | --- |
| **Dates** | **Therapist** | **Why** | **How Helpful (0-10)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Client’s Parent/Caregiver #1**

|  |
| --- |
| Is there anything stressful or unusual about the child’s relationship with parent/caregiver #1? |

|  |
| --- |
| How is the child disciplined by parent #1?  What reasons is the child disciplined by parent #1? |

**Client’s Parent/Caregiver #2**

|  |
| --- |
| Is there anything stressful or unusual about the child’s relationship with parent/caregiver #2? |

|  |
| --- |
| How is the child disciplined by parent #2?  What reasons is the child disciplined by parent #2? |

**Describe Your Child:**

|  |
| --- |
| Typical Behaviors: |

|  |
| --- |
| How do you respond to these behaviors? |

|  |
| --- |
| What behaviors distress you the most? |

|  |
| --- |
| Describe your child’s positive qualities |

|  |
| --- |
| Describe how this has impacted your:   * Marriage * Family   Describe how this has impacted your:   * Life * Self |

|  |
| --- |
| Describe your typical parenting and discipline techniques.   * Which are most effective? * What are least effective? |

|  |
| --- |
| Has anyone in your family felt physically threatened? |

|  |
| --- |
| What are your biggest worries? |

|  |
| --- |
| What are your hopes? |

**Symptom Checklist**

|  |  |  |
| --- | --- | --- |
|  | **NO** | **YES** |
| Clumsy and awkward |  |  |
| Stereotypic Behaviors (waves hands, stares blankly) |  |  |
| Self Destructive Behaviors (hair-pulling, biting, hitting, head banging etc) |  |  |
| Has frequent tantrums |  |  |
| Seldom makes eye contact |  |  |
| Demands too much attention |  |  |
| Is sluggish or slow moving |  |  |
| Often has physical complaints (headache, stomachache) |  |  |
| Usually plays alone |  |  |
| Disobedience/defiance |  |  |
| Asks for help when not needed |  |  |
| Gives up easily |  |  |
| Does not interact appropriately with others (parents, peers, siblings) |  |  |
| Physically abuses others (parents, peers, siblings, pets, toys) |  |  |
| Cries, whines or pouts frequently |  |  |
| Unreasonable noise making/yelling |  |  |
| Does not play with toys |  |  |
| Rarely obeys requests |  |  |
| Talks back to parents/authority |  |  |
| Reacts poorly when losing a game |  |  |
| Unreasonable fears |  |  |
| Does not recognize danger |  |  |
| Runs away frequently |  |  |
| Does not observe curfew |  |  |
| Will not play alone |  |  |
| Problems at mealtime |  |  |
| Sleep problems |  |  |
| Cannot feed self |  |  |
| Cannot dress self |  |  |
| Is not toilet trained |  |  |
| Is toilet trained but has accidents |  |  |
| Frequent lying |  |  |
| Stealing |  |  |
| Sets fires |  |  |
| Has sexually risky behaviors |  |  |
| Rages |  |  |
| Checks Out, gazes off, disengages |  |  |
| Outbursts seem to happen out of nowhere |  |  |
| Sadness |  |  |
| Excessive Worries |  |  |
| Other |  |  |
| Other |  |  |
| Other |  |  |
| Other |  |  |

What kind of help do you expect from me in working with your child?

Extra Notes:

Name of Person(s) completing this form:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_