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Child Intake Form

Date of Intake:_____________

Child's Name: ______________________________________ Date of Birth.: _______________

Address:____Phone:____________________

Age:__________ School:__________________________ Phone:________________

Teacher:__________ Grade: __________

Name of Parents:_____________________________ _________________________________

Best way to reach you:_____________________________________
(phone, email, etc.)

1. REASON FOR REFERRAL:

Who referred you?____

What do you perceive the problem to be?____

____

____

____

2. BACKGROUND INFORMATION

A. General background history

Name of Mother:____

Education:____

Profession:____

Name of Father:____

Education:____

Profession:____

List family members (siblings, other(s) living with child):

Relationship to child	Age	Gender	Lives at home?

B. Other pertinent background history

Parents' marital status?____

<u>If parents are not married, then</u>:
Do you have a significant other?___________

Does s/he live with the family?____________

How do(es) the child(ren) get along with him/her? _____________________________________

____

<u>If parent divorced or widowed</u>:

When (how old was the child)?____

Who has custody of the child?____

Relationship with non-custodial parent: (How often does your child see him/her?)_____________

____

<u>C. DEVELOPMENTAL HISTORY</u>

Pregnancy with child:____

____

Delivery and perinatal complications, if any?:____

____

How was your child as a baby?____

____

Developmental Milestones: (comment on any problems)

1. Motor____

2. Language:____

D. MEDICAL HISTORY:

1. Hospitalizations?____

2. Chronic Illnesses (e.g. asthma, diabetes, allergies, etc.)?________________________________

____

3. Allergies?____

4. Other illnesses?____

5. Accidents. If so, when and what happened?____

____

Loss of consciousness?______________For how long?__________________

Medication History (past and present):____

____

____

E. SCHOOL INFORMATION

How does your child do in school academically? ______________________________________

____

What are your child's grades?____

Special placement in school?____

Has your child been evaluated in the past?_______________________

Reason for evaluation:____

____

How does your child do in school behaviorally?____________________________________

Does your child have a learning or physical disability? __Y, __N, __Maybe.

Please specify: ____

Does your child have a mental health diagnosis? __Y, __N
Please specify:____

F. SOCIAL LIFE

1. Does your child have many friends?____

2. Does your child have problems socially? Please describe:)_____________________________

3. What kind of activities does your child do with her/his friends?___________________________

4. How does s/he get along with other children at school?_________________________________

5. What does your child do for fun? (activities, hobbies, sports, etc.)________________________

G. OTHER RELEVANT INFORMATION

Additional information that could help me understand your child better**:**

Briefly describe your goals for your child's therapy:

Thank you for taking the time to fill out this form.

Rebecca Toner, MFT