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Intake Form for Child Clients

Child (Client) Name:

Today's Date:

Please complete the following form. If a section is irrelevant to your child or you feel uncomfortable filling it out, please just draw a slash ("/") or write, "NA." If you are uncertain regarding the answer to a section, please just write a question mark ("?").

Child (Client) Information	
Date of Birth	
Gender	
Address	
Cell Number (if applicable)	
May I leave a message at this number?	Yes No
Ethnicity/Cultural Origin	
Sexual Orientation (if applicable or known)	
Religious or Spiritual Affiliation	
Other Cultural Considerations	

Legal Guardian #1 Information	
Name	
Date of Birth	
Address (if differs from Child)	
Cell Number	
May I leave a message at this number?	Yes No
Ethnicity/Cultural Origin	
Sexual Orientation	
Religious or Spiritual Affiliation	
Other Cultural Considerations	
Relation to Child (please circle)	Biological Mother/Father Adoptive Mother/Father Foster Mother/Father Step-Mother/Father Other
Occupation	
Medical Diagnosis/Diagnoses	
Mental Health Diagnosis/Diagnoses	

Past or Present Drug or Alcohol Abuse	Yes	No

Legal Guardian #2 Information		
Name		
Date of Birth		
Address (if differs from Child)		
Cell Number		
May I leave a message at this number?	Yes	No
Ethnicity/Cultural Origin		
Sexual Orientation		
Religious or Spiritual Affiliation		
Other Cultural Considerations		
Relation to Child (please circle)	Biological Father/Mother Adoptive Father/Mother Foster Father/Mother Step-Father/Mother Other	
Occupation		
Medical Diagnosis/Diagnoses		
Mental Health Diagnosis/Diagnoses		
Past or Present Drug or Alcohol Abuse	Yes	No

Parents'/Legal Guardians' Relational Status (please circle one):

Engaged/Married Dating Separated Divorced Widow/Widower

Who has legal custody of your child?

Who has physical custody of your child?

Is there an open Social Services Agency (SSA) case?

- If so, what is the reason for the open SSA case?

- Social Worker's Name:
- Social Worker's Phone Number:

Child School Information		
Present School Name		
Grade		
Present Grades/GPA		
Teacher Name (if in elementary school)		
Guidance Counselor (if in middle or high school)		
Has your child ever been retained ('held back') a grade? If so, what grade?		
Has your child ever been assessed for an Individualized Education Program (IEP) or 504 Plan?	Yes	No
Has your child ever qualified for an IEP or 504 Plan?	Yes	No
If your child has qualified for an IEP or 504 Plan, when did the services commence (and end if relevant)?		
Reason for IEP or 504 Plan		
Has your child ever been tested for giftedness?	Yes	No
Has your child ever been enrolled in a gifted program?	Yes	No
Middle School Name (if in high school)		
Middle School Grades/GPA (if relevant)		
Elementary School Name (if in middle or high school)		
Elementary School Grades/GPA (if relevant)		
Has your child ever received tutoring or academic support of any kind? If so, please describe what subject/age/etc.		

What was your child's reaction to each change in school (moving from elementary to middle, middle to high if relevant)? Stressful? Exciting? Please describe.	

Child Medical Health Information		
Medical Diagnosis/Diagnoses (such as asthma, allergies, epilepsy, diabetes, etc; please describe)		
Past or Present Prescription Glasses		
Start (and End if relevant) Dates of Prescription Glasses Use		
Past or Present Injury (please describe)		
Date(s) of Injury		
Past or Present Surgeries (please describe)		
Date(s) of Surgeries		
Has your child been hospitalized for medical reasons?	Yes	No
Date(s) of Medical Hospitalization		
Reason for Medical Hospitalization		
Past or Present Head Trauma/Injury (please describe)		

Date(s) of Head Trauma/Injury		
Past or Present Loss of Consciousness	Yes	No
Date(s) of Loss of Consciousness		
Any Other Medical Trauma (please describe)		
Hearing Difficulties	Yes	No
Vision Difficulties	Yes	No
PRESENT Medication (please include dosage)		
Reason for Present Medication		
Start Date of Present Medication		
Present Medication Prescriber		
Present Medication Prescriber Address		
Present Medication Prescriber Phone Number		
PAST Medication (please include dosage AND dates of use)		
Reason for Past Medication		

Past Medication Prescriber		
Primary Physician Name		
Primary Physician Address		
Primary Physician Phone Number		
Past or Present Drug Use	Yes	No
Past or Present Alcohol Use	Yes	No
Past or Present Drug Rehabilitation	Yes	No
Past or Present Speech Therapy	Yes	No
Past or Present Occupational Therapy	Yes	No
Past or Present Physical Therapy	Yes	No
Other Medical Treatment (please describe)		

Child Mental Health Information	
Past Mental Health Diagnosis/Diagnoses	
Reason for Seeking Mental Health Services in the Past	
Start Date of Past Mental Health Services	

End Date of Past Mental Health Services		
Past Mental Health Provider Name		
Reason for Ending Mental Health Services		
Past Psychiatric Hospitalization	Yes	No
Date(s) of Psychiatric Hospitalization		
Reason for Psychiatric Hospitalization		
Has your child completed psychological testing/assessment in the past?		
Dates of Psychological Testing/Assessment		
Reason for Psychological Testing/Assessment		
Name of Psychological Testing/Assessment Evaluator		
Outcome of Psychological Testing/Assessment		

Please explain your reason for seeking psychotherapeutic services for your child at this time.

When did the problem(s) start?

Is there a history of psychological or developmental disorders in the family (Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder, Schizophrenia, etc.)? If so, please describe.

Has your child experienced any event(s) in his/her life you would consider traumatic? If so, please describe.

Is there a history of drug or alcohol abuse in the family? If so, please describe.

Is your child experiencing suicidal ideation? If so, please describe.

Is your child experiencing homicidal ideation? If so, please describe.

Does your child self-harm (cut, burn, pick, choke, etc.)? If so, please describe.

Is your child seeing or hearing things that others do not? If so, please describe.

Has your child experienced abuse (sexual, physical, emotional, etc.) or neglect? If so, please describe.

Is your child **currently** experiencing abuse or neglect? If so, please describe.

Is your child physically aggressive with others? If so, please describe.

Child's Developmental Information	
Were your child's parents in a relationship at the time of your conception? If so, how long before his/her conception were his/her parents in a relationship? Friends, dating, marriage, etc.?	
Were your child's parents together as a couple when his/her mother was pregnant with him/her?	
Where were each of your child's parents residing while his/her mother was pregnant? Who was each parent living with (grandparents, aunts, friends, etc.)?	

How old were your child's parents when your child was conceived?	
Would your child's parents consider the pregnancy stressful? If so, please further describe stressors (finances, relational issues, etc.).	
Did your child's mother experience any physical/medical complications, diseases, or disorders (hypertension, diabetes, preeclampsia, etc.) while he/she was in the womb? If so, please describe.	
Did your child's mother receive regular prenatal care (ongoing access to her medical doctor/check-ups)?	
Did your child's mother experience any mental health concerns during the pregnancy (perinatal depression, mania, etc.)? If so, please describe.	
Was your child's mother taking any medications during the pregnancy?	
Did your child's mother utilize drugs or alcohol during the pregnancy?	
Did your child's mother have access to social support (family, partner, etc.) during the pregnancy? Please further describe social situation at the time.	
Was your child's mother working during the pregnancy? If so, where/doing what? How far into the pregnancy did she work?	
If relevant, was your child's other guardian working during your child's	

mother's pregnancy? If so, where/doing what?	
Complications at Birth (please describe)	
Born via C-Section or Vaginal Delivery	
IVF (in vitro fertilization) Birth?	
Developmental Concerns or Delays (please describe)	
Age of First Smile	
Age of First Roll Over	
Age First Sat Unassisted	
Age Began Pointing to Desired Objects	
If breastfed, at what age did breastfeeding end?	
Age First Bottlefed	
Age Bottlefeeding Ended	
First Teeth	
Age First Slept Through the Night (6 Hours)	
Age First Recognized Immediate Family	
Age First Recognized Extended Family	
Age First Began to Crawl	
Age First Started Feeding Self	
Age First Started Pulling Self Up to Stand	
Age First Started Walking	
Age First Started Running	
Age Spoke First Words	
Language of First Words (i.e. Spanish, English, etc.)	
Age Spoke Full Sentences	
Age Acquired Second Language	
Age Entered Daycare	

Reaction to starting daycare? Anxious? Clingy to parents? Curious? Please describe.	
Age Entered School (i.e. preschool or kindergarten)	
Reaction to starting school? Anxious? Curious? Please describe.	
Who typically cared for/babysat your child prior to entering daycare or school?	
Age Potty Trained (Urination)	
Age Potty Trained (Defecation)	
Age Began Imaginary Play	
If your child has younger siblings, how did he/she initially react to their birth(s)? How has (have) the relationship(s) changed/stayed the same over the years? Please describe.	

Child's Family Information	
Biological Sibling Name (s) and Dates(s) of Birth	
Half-Sibling Name(s) and Date(s) of Birth	
Step-Sibling Name(s) and Date(s) of Birth	

Step-Mother(s) Name(s) and Date(s) of Birth (if not legal guardian)	
Step-Father(s) Name(s) and Date(s) of Birth (if not legal guardian)	
Anyone your child is particularly close with?	
Other Individuals Residing in the Home	
Where has your child lived in the past and with who? Please start from birth.	
If your child has moved since birth, please describe how each move was for him/her. Stressful? Exciting?	

Child's Social Information	
Age First Began Developing Friends	
Initial Reaction to Peers Upon Entering School (please describe)	

Friend Status in Elementary School (please describe: i.e. frequently alone, 2-3 friends, various changes, etc.)	
Friend Status in Middle School (if in middle school or high school)	
Friend Status in High School (if in high school)	
Has your child ever been bullied? If so, please describe.	
Has your child ever bullied others? If so, please describe.	
Age First Began Demonstrating Romantic Interests	
Age First Began Dating	
Age Came Out as LGBTQ+ (if relevant)	
If your child identifies with the LGBTQ+ community, who is aware of their sexual orientation and/or gender identity?	

If your child identifies with the LGBTQ+ community, who did he/she first inform and how did the situation go?	

Child's Legal Information		
Incarcerations (please describe)		
Crime Involvement (please describe)		
Past or Present Probation	Yes	No
Dates of Probation		
Reason for Probation		
Present Probation Officer Name		
Present Probation Officer Phone Number		
Past Probation Officer Name		
Past Probation Officer Phone Number		
Gang Involvement	Yes	No
Conservatorship	Yes	No
Conservator's Name		
Conservator's Phone Number		

Child's Employment Information	
Employment Status (i.e. unemployed, full-time, part-time, etc.)	
Employer	
Past Employers and Dates of Employment	
