Northwest Counseling
Individual and Family Therapy

CHILD INTAKE FORM

Client Information Forms: This is to be completed by the parent, guardian or family member. Important: If there are court documents regarding custody, please bring to the intake appointment. (Please complete in Ink)

Primary Insurance Company: _____
Effective Date: _____
(If policyholder is different than client information above):
_____
First Name MI Last Name Social Security # _____
Address: _____
DOB: _____
Relationship to Client: _____
Employer: _____

Secondary Insurance Company: _____
Effective Date: _____
(If policyholder is different than client information above):
_____
First Name MI Last Name Social Security # _____
Address: _____
DOB: _____
Relationship to Client: _____
Employer: _____

It is your responsibility to inform Northwest Counseling of changes in address, phone #, and insurance coverage.

Parent Name:_____
Address (Street and Number):_____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____-_____
May We Leave a Message
- Yes
- No

Cell/Other Phone: (_____) _____-_____
May We Leave a Message
- Yes
- No

How do you want to receive appointment reminders?
- Email

- Text
- Phone
- I do not need reminders

E-mail:
May We Email You?

- Yes
- No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation:
Place of Employment:_____
Work Number: (_____) _____-_____
If needed, is it OK to call here?

- Yes
- No

Emergency Contact:
Name:_____
Relationship:_____
Phone Number: (_____) _____-_____

Date of first appointment:

Referred by:

- Medical Provider: _____
- Insurance Provider: _____
- Website: _____
- PsychologyToday: _____
- Friend/Family: _____
- Other: _____

Have you previously received any type of mental health services?

- Yes
- No

If yes, which of the following:

- Psychotherapy
- Medication
- Outpatient Hospitalizations
- Inpatient Hospitalization

If yes, please provide:

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Name of provider or facility:_____

Location:_____

Dates of treatment:_____

Reason for treatment:_____

CHILD

1. Child's Name_____Sex_____Age_____DOB_____

2. Natural Child Yes / No If adopted, at what age_____ Foster since _____

3. Parent's Names (include step-parents, foster parents, inc.)

_____
_____

4. Comments about custody and visitation (if applicable):

_____
_____

5. Primary reason you are concerned about your child?

_____
_____
_____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

__Sleep problems
__Lack of interest in activities
__Unassertive
__Fatigue/low energy
__Concentration problems
__Appetite/weight changes
__Withdrawal
__Suicidal thoughts or threats
__Suicidal plans / attempts
__Mood swings
__Depression
__Changed level of activity
__Cries easily

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__Forgetful/memory issues
__Short attention span
__Aggressive behavior
__Talks excessively / interrupts
__Can't sit still
__Not interested in peers
__Picked on / bullied by peers
__Easily distracted
__Irritable
__Impulsive
__Difficulty following rules
__Problem completing schoolwork

__Excessive worry / fearfulness
__Anxiety or panic attacks
__Social fears, shyness
__Separation problems
__Bedwetting / soiling
__Headaches, stomachaches
__Odd beliefs / fantasizing

__Lying
__Trouble with the law Running away
__Truancy, skipping school
__Hurting others sexually
__Alcohol / drug use
__Argumentative / defiant Swears
__Blames others for mistakes

__Nightmares
__Frequent tantrums
__Resistive to change
__School refusal
__Perfectionism
__Odd hand / motor movements Hallucinations
__Stealing
__Being destructive
__Fire setting
__Hurting others / fighting
__Acts as if has no fear
__Short tempered
__Easily annoyed / annoys others Discipline problem
__Angry and resentful

School History
Present School: _____Grade: ____

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Is child in special education services? No ____ Yes, what kind?

_____

_____

Please describe academic or other problems your child has had in school

_____

_____

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____ Delivery: Normal _____ Breech _____ Cesarean _____ Transectional _____
Full-term _____ Premature _____ if premature, number of weeks _____
Birth Weight: _____
Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)

_____

_____

Developmental History

State approximate age when child did the following:

- Understood and followed simple directions _____
- Age reached bowel control: day_____ night ____
- Age reached bladder control: day_____ night ____
- Did child cry excessively? _____ Rarely cried _____

Walked alone _____ Said first word _____ Used 2-word phrases _____ Rolls over_____ Crawls_____ Runs_____ Throws ball_____ Sits without support_____ Rides tricycle_____ Fine motor and gross motor coordination_____ Speaks several words_____ Names several objects_____ Puts 3 words together _____ Smiles_____ Shy with strangers_____ Separates from parent _____ Cooperative play with others _____

List any occupational services child has received: _____
List any speech services child has received: _____

Sexual Development

Has your child sought information regarding sex from you? Yes/No
If yes, what information and how was this handled?

_____

_____

Has this child behaved or spoken in a way that has not been sexually appropriate for a child his or her age? Yes/No

If yes, please describe:

_____

_____

Are you concerned about your child's sexual behaviors? Yes/No
Please describe

_____

_____

Birth and Postnatal Period

Birth weight _____ Birth length _____Labor duration_____
Delivery, please circle: Vaginal C-Section Full term Premature
Any complications: _____
Did mom have any mental health concerns following delivery? Please list

_____

Primary care of child the first year_____
Care after the first year_____
Was the child separated from parents? Please list why, age and length of time:_____

_____

_____

Health History of Child

In the first two years, did your child experience: ___Separation from mother, ___Out of home care, ___Disruption in bonding, ___Depression of mother, ___Abuse, ___Neglect, ___Chronic pain, ___Chronic Illness, ___Parental Stress

- Child's Doctor: _____
- Date of last physical exam: _____
- Vision problems? Yes _____ No_____ Hearing problems? Yes _____ No _____
- Dental problems? Yes ____ No ____
- Any head injuries or loss of consciousness? Yes _____ No _____
- Child's history of serious illness, injury, handicaps, or hospitalization?

_____

_____

If yes, please list where (clinic) it is on file _____

Any previous testing (school/psychological)? No _____ Yes _____

Whom/where _____when_____

Do you think your child's use of chemicals is a problem? No _____ Yes _____

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Type: Alcohol _____ Marijuana _____ Other drugs _____
Comments: _____

Family History
Chemical use (now & past): No _____ Yes _____ Which parent _____
Type: Alcohol _____ Marijuana _____ Other drugs_____

List any history of mental illness or addiction in **immediate or extended family** (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

Condition	Yes/No	List Family Member
ADHD	Yes/no	
Anxiety	Yes/no	
Depression	Yes/no	
Domestic Violence	Yes/no	
Suicide Attempts	Yes/no	
Obsessive Compulsive Disorder	Yes/no	
Other diagnosed mental health condition	Yes/no	Please list:

Condition	Yes/No	List Family member
Drug use or addiction	Yes/no	
Alcohol use or addition	Yes/no	
Parental conflict/violence	Yes/no	
Foster care placement	Yes/no	
Family legal problems	Yes/no	
Schizophrenia	Yes/no	
Bipolar	Yes/no	

Has child witnessed domestic violence? __Y, __N,
Specify:_____
_____
_____

Has child experienced divorce? __Y, ___N

If yes, at what age?_____

How is your child disciplined? Please list each method and frequency of use:

_____
_____
_____

List Family members currently living in the same household as the child

Name	Age	Relationship to the child

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? __Y, __N, __Suspected. Specify:

_____

2. Has your child been physically abused? __Y, __N, __Suspected. Specify:

_____

3. Has your child been sexually abused? __Y, __N, __Suspected. Specify:

_____

4. Other stressors or traumas?

_____
_____

Has child experienced any of the following stressors? Please list:

Event	Year	Child's reaction
Moved		
Changed schools		
Serious injury/illness in family		
Death		
Sibling leaving home		
Change in parent job		
Other stressor, please list:		

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What are your child's strengths?

_____
_____
_____
_____

Anything else you would like to share that was not asked on this form?

_____
_____
_____
_____