Child Intake Assessment Form

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Today's Date:_____

General Information

Name: _____

(Last) (First) (Middle Initial) (Preferred)

Name of parent/guardian filling out form (if under 18 years)

_____

(Last) (First) (Middle Initial) (Relationship)

Date of Birth: _____/_____/_____ Gender: [ ] Male [ ] Female

Address: Street and Number _____

City, State, Zip _____

Phone: Home - _____ Cell - _____

May we leave messages? [ ] Yes [ ] No

Email address: _____

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

Referred by (if any): _____

Presenting Problem – Describe in your own words why you are bringing the child in today?_____

_____

_____

When did the problem start? _____

Demographic Information

Race: _____ Language: _____

Ethnicity: _____ Religion: _____

Education

Current School:

_____

(School) (Last Grade Completed) (Graduated? Y or N)

Is or was school performance a concern for you? If yes, please explain:

_____

_____

Family

The child currently lives with: _____

How long in present living arrangement? _____

Other household members currently living in the home with you:

(Name) (Age) (Sex) (Grade/Occupation) (Relationship to you)

_____

_____

_____

Are there any recent (last 6 months) events currently producing family stress? [ ] Yes [ ] No

If Yes, please explain? _____

Health History

Primary Physician: _____

Primary Physicians Phone: _____ Date of last exam: _____

List any Allergies: _____

List any previous surgeries: _____

Does the child currently take any medications? [ ] Yes [ ] No If Yes, please list:

_____

_____

Has the child ever been prescribed psychiatric medication? [ ] Yes [ ] No If Yes, please list:

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.):

	Please check	List family member
Alcohol/Substance abuse	[ ] Yes [ ] No	
Anxiety	[ ] Yes [ ] No	
ADHD	[ ] Yes [ ] No	
Depression	[ ] Yes [ ] No	
Domestic Violence	[ ] Yes [ ] No	
Learning Disabilities	[ ] Yes [ ] No	
Major Legal Problems	[ ] Yes [ ] No	
Obesity	[ ] Yes [ ] No	
Obsessive Compulsive Disorder	[ ] Yes [ ] No	
Psychotic Behavior	[ ] Yes [ ] No	
Suicide Attempts	[ ] Yes [ ] No	

Abuse History

Has your child ever experienced physical, sexual, or emotional abuse? [ ] Yes [ ] No If yes, please explain:

_____

Substance Abuse

Does your child drink alcohol more than once a week? [ ] Yes [ ] No If yes, how often? _____

Is alcohol an area of concern for you? [ ] Yes [ ] No If yes, please explain? _____

Does your child use tobacco more than once a week? [ ] Yes [ ] No If yes, how often? _____

Is tobacco an area of concern for you? [ ] Yes [ ] No If yes, please explain? _____

How often does your child participate in recreational drug use? [ ] Daily [ ] Weekly [ ] Monthly [ ] Never

Is recreational drug using an area of concern for you? [ ] Yes [ ] No If yes, please explain? -

_____

Legal History

Does your child have a history of any legal charges? [ ] Yes [ ] No If yes, please explain:

_____

Is your child currently on probation? [ ] Yes [ ] No If yes, please explain:

_____

Is treatment court ordered? [ ] Yes [ ] No If yes, please explain:

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate the child's current physical health?

[ ] Poor [ ] Fair [ ] Good [ ] Very Good [ ] Excellent

Please list any specific problems they are currently experiencing:

_____

How would you rate the child's current sleeping habits?

[ ] Poor [ ] Fair [ ] Good [ ] Very Good [ ] Excellent

Please list any sleep problems they are currently experiencing:

_____

Please list any difficulties the child experiences with their appetite or eating patterns:

_____

Medical History

Medical Conditions

Check all that apply:

[ ] No major medical/psychiatric conditions
[ ] Asthma
[ ] ADHD
[ ] Chronic Ear Infections
[ ] Bedwetting
[ ] Diabetes
[ ] Fetal Alcohol Syndrome
[ ] Lead poisoning
[ ] Multiple Sclerosis
[ ] Muscular Dystrophy
[ ] Seizure Disorder
[ ] Spina Bifida
[ ] Other: _____

Developmental Information

Pregnancy and Birth information

[ ] Born with no apparent complications
[ ] Experienced anoxia at birth
[ ] Experienced in utero exposure
[ ] Required assistance with breathing
[ ] Born past due
[ ] Was born premature
[ ] Weighed less than 5 pounds at birth
[ ] Spent time in the neonatal ICU
[ ] Other: _____

Developmental Milestones Achieved

Check one for each milestone –	Early	Typical	Late	Unknown
Sitting alone	[ ]	[ ]	[ ]	[ ]
Crawling	[ ]	[ ]	[ ]	[ ]
Standing alone	[ ]	[ ]	[ ]	[ ]
Walking alone	[ ]	[ ]	[ ]	[ ]
Speaking first words	[ ]	[ ]	[ ]	[ ]
Speaking short sentences	[ ]	[ ]	[ ]	[ ]
Using toilet when awake	[ ]	[ ]	[ ]	[ ]
Staying dry at night	[ ]	[ ]	[ ]	[ ]

Sensory/Motor Status

Check all that apply

[ ] Has no sensory or motor problems
[ ] Has visual difficulty
[ ] Is supposed to wear corrective lenses
[ ] Has a mild hearing difficulty
[ ] Has a substantial hearing difficulty
[ ] Has an allergy related hearing difficulty
[ ] Is supposed to wear a hearing aid
[ ] Has Pressure Equalization (P/E) tubes
[ ] Has fine motor movement difficulties
[ ] Has gross motor movement difficulties
[ ] Other: _____