Child Intake/Assessment Name:______________________

Child's Name:_________________________________

What are your current concerns regarding your child?

____

____

___ temper tantrums	___impulsive	___frequent illness	___stubborn
___eating/feeding difficulties	___irritable	___withdrawn	___fearful
___hitting/kicking/pinching	___peer conflict	___throwing things	___rocking
___learning difficulties	___self-harming	___anger outbursts	___stealing
___odd behaviors	___strange thoughts	___sleep problems	___clumsy
___nightmares	___fire setting	___school problems	___destructive
___no fear of strangers	___toileting accidents	___sexualized behaviors	___infantile
___suicide talk	___anxiety	___unexplained fears	___defiant
___restless/can't sit still	___can't keep attention	___daydreams	___bites

When did you first notice these concerns ____

____

If therapy can help with one thing, what do you hope it will be? ______________________________

____

How long do you anticipate your child to be in therapy? ____________________________________

Have you or your child received mental health/counseling services before? ___________________

If yes, was it a positive or negative experience and why? ___________________________________

____

Are there any current family stressors or situations that are affecting your family's functioning?

____

____

Does your child live with anyone else part of the time? _____________________________________

Describe your child's typical day: ____

____

____

What are your child's strengths/talents? ____

____

How well does your child respond to your attempts to soothe or comfort her/him when upset?

____

How well does your child fall asleep, stay asleep, or wake up in the morning? _________________

____

How does your child react to everyday experiences: bathing, hair washed, wearing new clothes, loud sounds/noisy situations, bright lights, etc.?____

Child Intake/Assessment Name:______________________

____

Child's Developmental History

Were there any complications/difficulties during the pregnancy, at the time of birth, or in the first year for the child or mother? ____

____

Was child planned ___ yes ___ No Typical pregnancy ___ yes ___ no

If not, what occurred?____

Did mother use alcohol/drugs during pregnancy? ___yes ___no if yes, type______________________

Length of labor: ______ hrs _____easy _____difficult Delivery: ___ vaginal ____ cesarean

Full term: ___yes ___ no Apgar score: ___________________________

If premature, how early________________ birth weight__________________ height________________

Did the infant require: Oxygen ___yes ___no Blood transfusion:___yes ___no X-ray:___yes ___no

Developmental Milestones: Age at which child -

Sat up: ____________________ Crawled: _____________ Toilet Trained: ___________________

Spoke first words: _____________ Spoke Full Sentences: _____________ Walked:_______________

Child's Medical History

Does the child have any current medical concerns?____

____

Any Allergies (medicine, food, environment)?____

Any history of seizures?____

Has your child experienced any head injuries? ____

Has your child ever been hospitalized?____

Age/Length of time?____

Any significant past medical conditions?____

Is your child currently taking any medication?____

How long/reason?____

____

Social History

Who provides care for your child or is an important influence on your child?______________________

____

Has your child lived outside of your home for any period of time?_______________________________

if yes, please explain____

Has your child ever experienced any situation where she/he has had multiple of inconsistent care-givers?____

____

Has your child ever been exposed to, witnessed or heard violence between other people? __________

if yes, please explain____

Has your child been a victim of physical, sexual or emotional abuse or neglect?___________________

if yes, please explain____

Child Intake/Assessment Name:______________________

____

Family History

Who is an important source of support for your family?______________________________________

____

How does your culture influence you and your family?____

____

Is there anything about your cultural background that you think would be helpful in understanding your family?____

____

What type(s) of discipline strategies do you use with your child?_____________________________

____

____

Who in the family does your child remind you of the most?_________________________________

____

Has your child experienced a divorce or separation? ____ yes, child's age:______ ____ no

If yes, when and what were the circumstances____

____

If yes, is there any continuing legal involvement? ____

____

Is there any history of mental illness in the family (including extended family)? __________________

If yes, please explain____

____

Is there any history of substance abuse in the family (including extended family)?_________________

If yes, please explain____

____

Is there any history of domestic abuse/violence in the family (including extended family)?__________

if yes, please explain____

____

Is there anything else you feel would be helpful for me to know about your child or family? ________

____

____

____

Name of Guardian:____ Date:_________________

Child Intake/Assessment Name:____________________

Signature:____

Relationship to child:________________________________