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Child Intake

Please provide the following information about your child:

Childs Full Name: ____

Nick Name: ____

Birth Date: ________________ Today's Date ______________

If adopted:

Adopted from: _______________ at age: ____ Agency: _________________

(On reverse write what you know of your child's history before joining your family)

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that causes concern? List all behaviors you can think of. ______________________
____
____

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? List all the behaviors you can think of.
____
____
____

Behavioral Assets:
What does child do that you like? What does he/she do that other people like? _
____
____

Others Concerns:

___ Fire starting
___ Sleep problems
___ Poor eye contact
___ Lying
___ Stealing
___ Lacks remorse
___ Tantrums
___ Eating problems
___ Lacks boundaries

Describe other concerns about your child or your family not listed yet:
____
____

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, which problem behaviors do you want to see change FIRST, and how much must they change for you to be comfortable? ______________________________________
____
____
____

Family History
The name of the child's biological parents:

Mother: ________________________ Father: ___________________________

Who has legal guardianship of your child? ______________________________

List who your child lives with:

Name	Age	Relationship to child	Grade/Job

List here any significant others NOT living with your child:

Name	Age	Relationship to child	Grade/Job

Describe any past counseling for child or any family member: _______________
____

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? ____ If yes, Please describe: _______________________

Education History
What school does your child attend? ___________________________________

Current grade: _______________ Teachers Name: _______________________

What does your child's teacher say about him/her? _______________________

Has your child ever repeated a grade? ________ If so which one(s): __________

Has your child ever received special education services? __________________

Check concerns your child experiences at school or daycare?

__ fighting __ lack of friends __ drug/alcohol use
__ learning disabilities __ incomplete homework __ behavior problems
__ poor attendance __ poor grades __ gang influence

Medical History

What is the name of your child's medical doctor? ___________________________
Address: ________________________ Phone: ___________________________
Date of your child's last medical examination: ___________________________
Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? _________ If so, please list which ones: _____________
____
Did the child's mother have any problems during the pregnancy or delivery? ___
If so, Please describe them: ____

Has your child experienced any of the following medical problems?

__ A serious illness __ Hospitalization __ Surgery
__ Ear/Hearing Problems __ A head injury __ High fever
__ Convulsions/seizures __ Eye problems __ Meningitis
__ Hearing problems __ Asthma __ Allergies
__ Loss of consciousness __ Parasites __ Other:

Please list any current medical problems or physical handicaps: _____________
Please list any medications your child takes on a regular basis: ______________

Other History

Has your child ever experienced any type of abuse?
__ physical, describe: ____
__ sexual, describe:____
__ ,verbal/emotional, describe:____

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else? ____
Has he/she ever purposely hurt himself or another?_________________________
Run away from home: ____
If yes to above questions please describe the situation: _____________________
____
Has your child ever experienced any significant loss/trauma:

__ separation from mother __ separation from father __ home fire
__ death of someone close __ witnessed violence __ neglect
__ frequent moves __ loss of a pet ___ other: ________________

Finally, what are any other things that are currently stressful to your child and your family? ____
____
____