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Client Intake Child:

Name:_____DOB:_____Age:_____
Gender:_____Grade:_____School_____
Pediatrician:_____
Health Issues:_____
Medications:_____

HISTORY OF PRESENT PROBLEM:

What concern(s) bring you into to counseling:
_____
_____
_____
_____
_____
_____
_____
NO EXTREME SYMPTOMS/STRESS SYMPTOMS/STRESS
Have you ever had the same or a similar condition? o[?]Yes o[?]No.
If yes, when and describe:_____
_____
How did it originally occur?_____
Has it become worse recently? o[?]Yes o[?]No o[?]Same o[?]Better o[?]Gradually Worse.
If yes, when and how?_____
How frequent is the condition? o[?] Constant o[?]Intermittent.
What causes the problem to come on/get worse?_____
Is this problem impacting your: o[?]Work o[?]School o[?]Social life o[?]Relationships o[?]Ability to function
Does anything make the concern better? If yes, please explain_____
_____
Are there any other conditions you would like to discuss? o[?]Yes o[?]No.
If yes, describe:_____

Milestones

Walking_____talking_____potty training_____separation_____
Independent functioning_____parallel play_____
Imaginary play_____interactive play_____

School Functioning:

What specific goals/objectives would you like to work on in therapy? And/or what would you like to have happen as a result of therapy?

1. _____
2. _____
3. _____

ExtracurricularActivities

_____

_____

SUPPORT SYSTEM: Who do you turn to for support?_____
Please list those that live in your home and their relationship to you:_____

_____

Quality of Relationship (S)– i.e. Close, Good, Fair, Poor, Enmeshed, Strained, Conflicted, Non-existent, Other:_____

CURRENT PSYCHIATRIC CARE:

Are you currently seeing a psychiatrist: o[?]Yes o[?]No
if yes, please list who_____
Do they know you are seeing me? o[?]Yes o[?]No. If No, can they be informed? o[?]Yes o[?]No
List medications prescribed by your psychiatrist:_____

_____

Date of last appointment:_____
Date of next appointment:_____

FAMILY HISTORY

Are your parents: ____ Married/Partnered ____ Separated ____ Divorced (year____) ___Never Married
Cause of death and age at death if deceased: _____
List names and ages of any Siblings:_____
Children:_____
Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.
Do you have any family members who suffer from the same condition you do? _____ If so, please list: _____
FAMILY DISEASES (if applicable and indicate whether family member is Father, Mother, Sister, Brother):
__ Anxiety __ HIV
__ Depression __ Eating Problems
__ OCD __ Traumatic Stress Issues
__ Anger __ Attachment Issues
__ Abandonment __ Personality Issues. List: _____
__ Alcoholism __ Other. List: _____
__ Drug Addiction __ Other. List: _____
Mom'sside:_____

_____

Dad's side:_____

_____

Are you currently feeling like you want to hurt or kill yourself?
o? Yes o? No Do you have a plan?
o? Yes o? No
Are you currently feeling like you want to hurt or kill someone else?
o? Yes o? No Do you have a plan?
o? Yes o? No
Do you purposefully, physically hurt yourself?
o? Yes o? No – If yes – how:_____
Are you currently being abused?
o? Yes o? No
If yes, by who and how?_____
Are you currently involved in or being exposed to a relationship that contains domestic violence?
o? Yes o? No
*Do you have a history of ANY of the previous risks listed above? o? Yes o? No
If yes, please explain: _____
_____
_____
o? Check here if this is your first and only Psychiatric/Psychological/Counseling experience.
Previous therapist:_____
Dates of treatment:_____
Reason for termination: work completed ( ), was not satisfied ( ), other:_____
_____