Confidential

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WELLNESS CENTER
growing together

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CLINICAL INTAKE FOR CHILDREN

Patient Name: _____ **Birth Date:** ____/ ____/ ____

Referred By: **Age:** _____ **Gender:** Other

FAMILY INFORMATION

Legal Custody of Child: Parent- ❑ *Single* ❑ *Joint* ❑ Court-Appointed Lawyer ❑ Adoptive
❑ Grandparent Guardianship ❑ Foster Care ❑ Other- _____

Father's Name: _____ **Occupation:** _____ **Level of Ed.:** _____

Mother's Name: _____ **Occupation:** _____ **Level of Ed.:** _____

Status of Parents: (check where applicable)
❑ Parents Married ❑ Cohabitating ❑ Separated ❑ Divorced ❑ Deceased Mother - Father
❑ Remarried ❑ Mother single - Father single ❑ Mother in relationship - Father in relationship

Stepparent Name(s): (if applicable) _____ (stepmother) _____ (stepfather)

Sibling Name(s): _____ **Ages:** ____
_____ ____
_____ ____
_____ ____

Address: _____
_____

❑DO NOT mail notices (e.g. billing, announcements, reminders, etc.)

Family Composition: (e.g. Changes in custody, family composition, death, parental separation, new births)

_____

_____

Phone Numbers:	Mother	Father	Child
Home- ❑Do not leave message)	( ) _____-_____	( ) _____-_____	( ) _____-_____
Work- ❑Do not leave message)	( ) _____-_____	( ) _____-_____	( ) _____-_____
Cell- ❑Do not leave message)	( ) _____-_____	( ) _____-_____	( ) _____-_____

Father's Email Address: _____
Mother's Email Address: _____
Child's Email Address: _____

PATIENT INFORMATION

Religious Identification:
Current religious denomination/affiliation- ☐ Christian ☐ Nondenominational ☐ Jewish ☐ Islamic ☐ Buddhist ☐ Hindu ☐ Other (specify): _____

Involvement- ☐ None ☐ Some/irregular ☐ Active

How important are spiritual concerns in your child's life? _____

Which (if any) church, synagogue, temple, or meeting is your child involved with? _____

Racial/Ethnic Identification:
Ethnicity/National origin- _____ Race- _____ or other similar way your child identify him/herself and consider important- _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Phone Number	Alternative Number

BACKGROUND INFORMATION

What do you enjoy *most* about your child?: _____

_____

_____

What do you enjoy *least* about your child?: _____

_____

_____

Describe your child's strengths: _____

_____

_____

Describe your child's concerns: _____

_____

_____

Describe your relationship with your child:
Currently- _____

In the past- _____

Describe his/her relationship with other parent/primary caregivers: (step-parent, grandparent, etc.)
Currently- _____

In the past- _____

PATIENT HISTORY

Pediatrician: _____ **Phone:** _____

Pediatrician Office Name: _____

Birth: Complications during pregnancy- no
Medications during pregnancy- no
Alcohol or drugs- no
Complications during labor and delivery- no
Weight- _____lbs _____oz
Full Term- ☐YES ☐NO
Discharged after how many days? _____

Describe any delays during early development: (e.g. Walking, talking, playing, toileting, socialization)

_____

_____

Medical History: (Medications, broken bones, concussions, seizures, surgeries, hospitalizations, emergency room visits, significant injuries, significant illnesses, asthma, allergies, etc.)

	Condition/Diagnosis Given	Month/Year	Reason
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Physical and/or Sexual abuse: (Indicate whether incident[s] was reported or not, to whom it was reported, and what is the status or what was the outcome of investigation) _____

_____

_____

Current Medications:

1. _____ Dosage/Freq _____ Start Date _____ Purpose _____
2. _____ Dosage/Freq _____ Start Date _____ Purpose _____
3. _____ Dosage/Freq _____ Start Date _____ Purpose _____
4. _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribing Doctor[s]: _____

Current or upcoming treatments/medications/surgeries for medical conditions: _____

_____

_____

Child's Current Health: ☐Below Average ☐About Average ☐Above Average

Do any conditions affect your child's health?: _____

_____

Vision Exam: Date: ___/ ___/ ___ Results- _____

Hearing Exam: Date: ___/ ___/ ___ Results- _____

Previous Mental Health Assessments/Treatments:

	Service Provider	Month/Year	Reason and Diagnosis
1.			
2.			
3.			

Suicide Attempts: Has your child ever talked about or attempted any behaviors related to suicidal acts? If so, describe incident(s) and resulting action(s) (e.g. hospitalization, medication, etc)? _____

Self-Injurious Behaviors: (Cutting, burning, carving, hitting self, etc.) _____

Legal History/Status: (e.g. arrests, citations, custody hearings, detentions, pending court dates, probations)

Describe any significant medical/mental conditions affecting immediate family members and close relatives: (e.g. depression, anxiety, suicide, substance abuse) _____

EDUCATIONAL INFORMATION

Name of School: _____ **Grade:** _____

School Contact Person: _____ **Phone:** _____

Frequent School Changes: ☐ YES ☐ NO If yes, why? _____

Discipline and Attendance Record: (e.g. expulsions, suspensions, parent conferences, absenteeism, tardiness**)**

Any comments or statements made to you by educators about your child's abilities or learning?: _____

Did your child make satisfactory progress in kindergarten and first grade: ☐ YES ☐ NO If no, why?

Was your child ever retained a grade level: ☐ YES ☐ NO If so, why and when? _____

Strengths in school: _____

_____

Concerns in school: _____

_____

Child's attitude towards school: _____

What factors impact your child's ability to learn?: _____

_____

Has your child ever experienced an unusually difficult school year?: ☐YES ☐NO If so, When and why?

_____

_____

Current Supports in School: (e.g. Special Education, 504 Plan, after school activities, pull-out or in-class interventions for academics or behavior, Behavior Intervention Plans) _____

_____

_____

Academic Concerns:

◯ Reading ◯ Math ◯ Written Language ◯ Oral Language ◯ spelling ◯ Work Completion
◯ Understanding Directions ◯ Oral Comprehension ◯ Content Area ◯ Homework Completion
◯ Organization/Preparedness ◯ Vocabulary ◯ Other: _____

Educational Goals and Aspirations: _____

_____

SOCIAL RELATIONSHIPS

Does your child seem accepted or rejected by peers? What about with adults?: _____

_____

_____

Does your child have any social skills problems?: (i.e., greeting others, maintaining friendships, resolving conflicts, taking turns, etc.) _____

_____

Does your child prefer to play with older/younger children?: _____

_____

Does your child prefer to be alone?: _____

_____

Does your child have difficulty making friends and/or keeping them?: _____

_____

Participation in organized activities/church/sports/clubs?: _____

Hobbies and Interests: _____

How much time does your child spend with the computer, TV, and video games?: _____

_____

Family Activities: _____

_____

DAILY FUNCTIONING

Concerns	Check One	
Eating Problems (too much/too little)	☐ YES	☐ NO
Sleeping Problems (too much/too little)	☐ YES	☐ NO
Cries Often	☐ YES	☐ NO
Sudden Changes in Weight (Gain or loss)	☐ YES	☐ NO
Problems with Attention Span/Concentration/Memory/Organization	☐ YES	☐ NO
Frequent Sadness	☐ YES	☐ NO
Low Self-Esteem	☐ YES	☐ NO
Temper/Anger/Aggression Towards Self or Others	☐ YES	☐ NO
Unexplained Mood Swings (Highs and Lows)	☐ YES	☐ NO
High Levels of Anxiety/Stress/Fears/Worries	☐ YES	☐ NO
Ritualistic Behaviors (counting, checking, washing)	☐ YES	☐ NO
Obsessive Thoughts (unable to block out unwanted thoughts)	☐ YES	☐ NO
Withdrawal from Social Interactions	☐ YES	☐ NO
Loss of Interest in Previously Satisfying Activities	☐ YES	☐ NO
Possibility of Substance Abuse/Drug and or Alcohol Use	☐ YES	☐ NO
Lying/Stealing	☐ YES	☐ NO
Breaking Rules Frequently	☐ YES	☐ NO
Tics (involuntary movements or jerks)	☐ YES	☐ NO
Changes in Routines	☐ YES	☐ NO

What would you like your child to obtain from participation in therapy: _____

_____

Is there any additional information you would like to share with us about your child?: _____

_____

Completed By: _____ **Date Completed:** ____/ ____/ ____

THANK YOU!