Metro Counseling Center
Healing the Brokenhearted

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CHILD INTAKE ASSESSMENT FORM

IDENTIFYING INFORMATION

Today's date: ______________________

Child's name: __________________________________ Age: _______ Grade: _________

Date of birth: _______________________ Race/ethnicity: ___________________________

Religious affiliation: _______________________ Social security number: _________________

Person(s) completing this form: ____

Child's custodian/guardian(s) is/are: ____

Child's Home Address: ____

City ___________________________________ State ___________ Zip Code______________

Home Phone: _____________________ Other Phone (specify type): ______________________

Is it OK to contact you/child at home? yes no OK to leave a message? yes no

Special calling instructions? ____

Emergency Contact: _____________________________ Relationship to Child: _____________

Address: ____

City ______________________________ State _______________ Zip Code _______________

Home Telephone: ______________________ Other Phone (specify type): ________________

MOTHER'S INFORMATION

Mother's name: __________________________________ Date of birth: _______________

Phone: ____________________ Home Address: ______________________________________

City ___________________________________ State ___________ Zip Code______________

Race/ethnicity: ______________________________ Religious affiliation: __________________

Highest Grade Completed: _______________________

Marital/relationship status (Check one): Married Live with partner Single Widowed
Separated/Divorced or Other: ____

Employment status (Check all that apply): Employed retired disabled student
homemaker unemployed If/When employed, what type of work does mother do?

____

Current employer is: ____

Years on Current Job: ______________ Business Phone: _________________________

Is it OK to contact mom at work? yes no OK to leave a message? yes no

Special calling instructions? ____

FATHER'S INFORMATION

Father's name: ________________________________ Date of birth: ______________

Phone: __________________ Home Address: __________________________________

City _______________________________ State __________ Zip Code_____________

Race/ethnicity: __________________________ Religious affiliation: _________________

Highest Grade Completed: ____________________

Marital/relationship status (Check one): Married Live with partner Single Widowed
Separated/Divorced or Other: ____

Employment status (Check all that apply): Employed retired disabled student
homemaker unemployed If/When employed, what type of work does dad do?

____

Current employer is: ____

Years on Current Job: ______________ Business Phone: _________________________

Is it OK to contact mom at work? yes no OK to leave a message? yes no

Special calling instructions? ____

STEP-PARENT'S OR FOSTER PARENT'S INFORMATION

Name: _____________________________ Date of birth: ______________

Phone: __________________ Home Address: __________________________________

City _______________________________ State __________ Zip Code_____________

Race/ethnicity: __________________________ Religious affiliation: _________________

Highest Grade Completed: ____________________

Marital/relationship status (Check one): Married Live with partner Single Widowed
Separated/Divorced or Other: ____

Employment status (Check all that apply): Employed retired disabled student
homemaker unemployed If/When employed, what type of work does mother do?

____

Current employer is: ____

Years on Current Job: ______________ Business Phone: ___________________________

Is it OK to contact mom at work? yes no OK to leave a message? yes no

Special calling instructions? ____

STEP-PARENT'S OR FOSTER PARENT'S INFORMATION

Name: ________________________________ Date of birth: ______________________

Phone: ___________________ Home Address: _____________________________________

City __________________________________ State ___________ Zip Code______________

Race/ethnicity: _____________________________ Religious affiliation: __________________

Highest Grade Completed: ______________________

Marital/relationship status (Check one): Married Live with partner Single Widowed Separated/Divorced or Other: ____

Employment status (Check all that apply): Employed retired disabled student homemaker unemployed If/When employed, what type of work does mother do?

____

Current employer is: ____

Years on Current Job: _______________ Business Phone: ___________________________

Is it OK to contact mom at work? yes no OK to leave a message? yes no

Special calling instructions? ____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems your child is experiencing:

____

____

____

What has happened to cause you to seek help NOW?

____

____

____

What do you hope to be able to do or achieve as a result of treatment?

____

____

____

What do you consider to be other stresses in your child's life?

____

____

____

HISTORY OF THE PROBLEM

When did your child first start experiencing the problem(s) that brought you to the clinic today?

____

____

____

How often does the problem occur? ____
____
____

How long does it last? ____
____
____

Does your child have any thoughts of harming him/herself? No Yes

Has your child ever attempted to harm him/herself? No Yes If yes, please explain:
____
____
____

Does your child have any thoughts of harming someone else? No Yes Has your child ever attempted to harm someone else? No Yes If yes, please explain: ____________________
____
____
____

Has your child ever had previous therapy/counseling of any kind? No Yes

If yes, when and for how long? ____
____
____

What concerns were addressed in therapy? ____
____
____

Was this experience helpful (please explain)? _____________________________________
____
____

Has your child ever been hospitalized for emotional/behavioral problems? No Yes If yes, when/where was this: ____
____
____

Has your child been prescribed medications to control emotional/behavioral problems?

No Yes If yes, please list medications, when prescribed, and by whom:
____
____
____

To your knowledge, has your child experimented with alcohol/drugs? No Yes

Are you concerned that your child might have or be developing a problem with alcohol or drugs? No Yes If yes, please explain: ____
____
____
____

FAMILY

Has this child ever experienced any parental separations, divorces, or death? No Yes If yes, when? ____

How old was the child at the time? ________ Please describe the circumstances.
____
____
____

If parents are separated or divorced, who has custody of this child? ______________________
How often does the other parent see this child?

____ Weekly or more often ____ Once or twice a month ____ Few times a year ____ Never

Please list the age and sex for each sibling (including those deceased, and step-siblings): Age Sex Relationship to Child Living at home?
____
____
____

Other than any children already indicated above and parents, who else lives in the child's household? Please describe the relationship of this person to the child/family.
____
____
____

Has anyone in the child's family had treatment for emotional problems? No Yes

If yes, please briefly explain (who/when): ____
____
____

Has anyone in your family ever attempted or committed suicide? No Yes If yes, please briefly explain (who/when): ____
____
____
____

FAMILY/SOCIAL HISTORY & HEALTH

Describe father's present health: ____
____
____

Describe mother's present health: ____
____
____

Have **any** family members had any of the following (PLEASE CHECK IF YES)? If yes, please specify family member's relationship to this child. Include all extended family members up to three generations. **Please specify birth relationships, step parent relationships and/or foster/adopted relationships.**

Cancer ______________________ Severe head injury ______________________

Cerebral palsy ______________________ Tourette's syndrome ______________________

Sexual Abuse ______________________ Homosexuality ______________________

Food allergies ______________________ Diabetes ______________________

Alcohol abuse ______________________ Heart disease ______________________

High blood pressure ______________________ Kidney disease ______________________

Behavior disorder ______________________ Migraine headaches ______________________

Depression ______________________ Multiple sclerosis ______________________

Mental Illness ______________________ Physical disability ______________________

Drug usage ______________________ Physical abuse ______________________

Mental retardation ______________________ Stroke ______________________

Nervousness ______________________ Tuberculosis ______________________

Seizures/epilepsy ______________________ Alzheimer's disease ______________________

Reading problem ______________________ Other Learning Problem ______________________

Speech/language problem ______________________ Sickle cell anemia ______________________

Sleep Difficulties ______________________ Tics ______________________

Bipolar Disorder ______________________ Anxiety ______________________

Attention Deficit/Hyperactivity Disorder ______________________________________
Criminal Activity ____
Other significant health or emotional problem: ______________________________

What kinds of stressful events has your child experienced recently? ____________________
____
____
____

What kinds of stressful events have family members experienced recently? ________________
____
____
____

Which family member has the best relationship with the patient?

____

CHILD'S EDUCATION

School (name, address)

____

City ________________________________ State ___________ Zip Code______________

Grade: _________ Age: _________ Teacher: ______________________________________

Approx. Grades: ____
____

Describe any difficulties or problems your child is having in school:
____
____
____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his/her age? If not, please explain.

____
____

How would you rate your child's overall level of intelligence?

_____Below Average _____Above Average _____Average

PEER RELATIONSHIPS

How does your child get along with others his/her age? Please describe any problems.

____
____
____

CHILD'S DEVELOPMENT

Pregnancy and Delivery

Was this a planned pregnancy? No Yes Was the mother under a doctor's care? No Yes
Number of previous pregnancies: ________ No. of Miscarriages: ________ Describe any complications that occurred during the pregnancy: ______________________________________
____

What drugs/medications were used during the pregnancy? ________________________________
____

At this child's birth, what was the mother's age? _________ Father's age? __________ Length of pregnancy: ________ weeks Birth weight: ______ lbs. ______ oz. Length of labor: ______ ______________________ Child's condition at birth: ____________________________________
____

Mother's condition at birth: ____
____

Length of stay in hospital: Mother _____ days Child _____ days Is this child adopted? No Yes If yes, please provide adoption history: ____________________________________
____
____
____

Was this child breast-fed or bottle-fed? No Yes If yes, when was she/he weaned? _______ At what age was this child toilet trained? Days: ________ Nights: _________ Did bed-wetting occur after toilet training? No Yes If yes, until what age: _________ Did soiling occur after toilet training? No Yes If yes, until what age: ___________ Describe sleep patterns or problems: ____
____

Language difficulties? No Yes If yes, describe: ____________________________________
____
____

Delays with child are walking? No Yes If yes, describe: _____________________________
____
____

As a young child, did your child have problems getting along with others? No Yes If yes, describe: ____
____
____

Where there other problems experienced during the child's first year? No Yes If yes, describe: ____
____
____

Infancy-Toddlerhood

Were any of the following present during the first few years?

____did not enjoy cuddling	____was not calmed by being held
____difficult to comfort	____Colic
____excessive restlessness	____excessive irritability
____frequent head banging	____constantly into everything

Temperment: Please rate the following as appeared in infancy and toddlerhood

Activity Level: ____underactive ____average activity level ____overactive
Intensity: ____average ____feelings were often intense
Adaptability: ____resisted change ____adapted easily to change
Mood: ____often happy ____average range of moods ____often dissatisfied or irritable

Developmental Milestones
As best you can recall, list age of development, or check item at right:

	AGE	OR: EARLY	NORMAL	LATE
Walked without assistance:	____	______	______	______
Spoke first words:	____	______	______	______
Any speech/articulation problems?	____Yes	____No		
Toilet trained daytime:	____	______	______	______
Toilet trained nighttime:	____	______	______	______

Developmental Milestones
Please rate your child on the following skills:

	GOOD	**AVERAGE**	**POOR**
Walking	______	__________	______
Running	______	__________	______
Throwing	______	__________	______
Catching	______	__________	______
Shoelace Tying	______	__________	______
Writing	______	__________	______
Athletic Abilities	______	__________	______

CHILD'S MEDICAL CARE

Child's physician: ______________________________ Phone: __________________________
Address: ____
City ___________________________________ State ___________ Zip Code______________

How often does this child see a doctor? _________________ Date of last visit: _____________
Is this child currently on any medication? No Yes If yes, indicate type and reason:
____
____

Does your child have any history of the following (please check all that apply): surgeries hospitalizations high fevers serious accidents eye, ear, nose & throat problems digestive disorder head injuries seizures loss of consciousness serious illness allergies

Please list below details of any conditions you checked above, including any additional childhood illnesses and other medical conditions: Condition/hospitalizations, Age, Treated by whom? Outcome of treatment?
____
____
____

CHILD'S INTERESTS AND ACTIVITIES

Is this child involved in any extracurricular activities, such as school sports or music programs? Clubs or religious organizations? No Yes If yes, please describe: ____________
____
____

Please describe your child's strengths and positive characteristics:
____
____
____

Other information you feel is important and were not asked about:
____
____
____

HOME BEHAVIOR AND MOOD

______frequently irritable or moody
______can't seem to enjoy doing anything
______sad spells
______crying spells
______acts like a driven motor
______poor or low motivation
______doesn't seem to learn from experiences
______argues with or rude to teachers
______low self-esteem (makes negative statements about self)
______has ever been sexually abused
______nervous, anxious
______frequent headaches
______frequent stomachaches
______easily bored
______frequent arguing at home
______fearfulness
______can't seem to concentrate
______drug/alcohol/tobacco use
______eats (too much) or (too little)
______has ever been physically abused

______has had thoughts of or made comments about suicide

______very disorganized (loses things, has very messy room)

______difficulty sleeping: ___goes to sleep very late ___hard to get up in the morning
___very restless sleep ___bad dreams or night terrors

______has had a panic attack (rapid heartbeat, sweaty palms, feeling something bad is about to happen)

Thank you for your time and effort in completing this form!

Cindy Eldridge, MA, PLPC, NCC
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