



CHILD INTAKE EVALUATION

Part I To be completed by parent

1. IDENTIFYING INFORMATION

Child's Name: _____ Today's Date: _____

Gender: M _____ F _____ Age: _____ Birth Date: _____ Marital Status: _____

Custodial Parent(s) Name: _____

Home Address: _____ City, State, Zip: _____

Telephone (s): _____
(home) Mother (cell/work) Father (cell/work)

May we leave messages for you at home? Yes or No: _____ May we leave messages at work? Yes or No: _____

Grade in School: _____ School: _____ Phone: _____

Referred by: _____

Others living in the home: _____,
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

_____, _____,
(name, birthdate, relationship to client) (name, birthdate, relationship to client) (name, birthdate, relationship to client)

Emergency Contact: _____ Phone: _____

Insurance Information

Name of Insured: _____ Insured date of birth: _____

Address of Insured Person: _____ City, State, Zip: _____

Relationship of client to insured person: _____

Employer of insured person: _____

Insurance company: _____ Phone: _____

Insurance company address: _____ City, State, Zip: _____

Insurance identification number: _____ Group number: _____

Secondary insurance: _____ Phone: _____

Name of secondary insured: _____ Date of Birth: _____

Secondary company address: _____ City, State, Zip: _____

Secondary Identification number: _____ Group number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefit to the provider of services.

Date: _____

2. PRESENTING PROBLEMS

Describe the child's problem(s) that brought you here today:

Check any of the symptoms that the child has been having:			
Depression		Feeling hopeless	
Extreme sadness		Feeling tearful/crying spells	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight/appetite changes	
Problems getting along with family		Problems getting along with friends	
Doesn't seem to enjoy usual activities		Feeling of extreme happiness	
Trouble doing school work		Truancy	
Feeling stressed		Irritability	
Perfectionist		Expresses feelings of guilt	
Worries		Seems nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Tense/uptight	
Anger outbursts		Acting violently	
Running away		Harm to animals	
Has hurt or cut on themselves		Firesetting	
Running away			
Thoughts of killing self		Thoughts of killing others	

3. WHAT HAS BEEN DONE ABOUT THIS PROBLEM SO FAR?

Have you worked with the child's teacher or school counselor? Yes No
 If you have, please describe it below.

Name of Teacher or Counselor:	Date(s):

HAS THE CHILD BEEN IN COUNSELING BEFORE? Yes No

If the child has been in counseling before, please describe it below. Start with most recent time first.

A. When was the counseling?	Date(s):
Who did you see?	Name:
Explain what happened:	
B. When was the counseling?	Date(s):
Who did you see?	Name:
Explain what happened:	

HAS THE CHILD BEEN PRESCRIBED ANY PSYCHIATRIC MEDICATIONS? Yes No

If yes, please describe:	Date(s):

4. SUBSTANCE USE HISTORY (If Applicable) CHECK HERE IF N/A

Does the child use tobacco (any form)?	Current	Past	No
Does the child use alcohol?	Current	Past	No
Does the child use caffeine(any form, including cola drinks)?	Current	Past	No
Does the child use recreational drugs?	Current	Past	No

5. MEDICAL INFORMATION

Has the child seen a doctor within the past year? Yes <input type="checkbox"/> No <input type="checkbox"/>	
What was that for?	
Who is the child's doctor?	Phone:
Is the child taking any kind of medicine (prescription or over-the-counter)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please list any medications that the child is taking:	
Please list any major medical problems that the child has had such as chronic illness, serious illness, operations, injuries or trauma to the head, etc:	
Does the child have allergies to anything? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please describe any allergy problems that he/she may have:	
Does the child have problems with sleeping? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the child have problems with eating? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the child have problems with toileting? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Describe the problem(s):	
Has the child been affected by any issues such as witnessing violence, having accidents, experiencing loss or experiencing abuse (physical, sexual or emotional)? Yes <input type="checkbox"/> No <input type="checkbox"/> Please describe the relevant issue(s):	

6. DEVELOPMENTAL HISTORY

Were there any problems with the pregnancy or the delivery of the child? Yes <input type="checkbox"/> No <input type="checkbox"/>	
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Any problems with eating, sleeping or crying spells (colic, nightmares, etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did the child demonstrate any difficulties or delays in walking, talking, toilet training? Yes <input type="checkbox"/> No <input type="checkbox"/>
Have there been any family crisis such as marital separation or divorce? Yes <input type="checkbox"/> No <input type="checkbox"/>
Have there been any mental health problems in the family of origin? Yes <input type="checkbox"/> No <input type="checkbox"/>
Have there been any substance use or abuse issues in the family? Yes <input type="checkbox"/> No <input type="checkbox"/>
Briefly describe the child's relationship to parents:
Briefly describe the child's relationship to siblings?
Briefly describe the child's temperament?

7. SCHOOL HISTORY

When did the child start school?
Were there any problems when the child started school? Yes <input type="checkbox"/> No <input type="checkbox"/>
What problems have come up during the school years?
What grades is the child getting?
How does the child get along with his or her teachers?
How does the child get along with his or her friends or peers in school?
What are the child's favorite subjects or school activities?
What subjects or activities does the child have problems with?

8. Child Checklist of Characteristics

Please review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child. Feel free to add any others at the end under “Any other characteristics”.

- Affectionate
- Argues, “talks back”, smart-alecky, defiant
- Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- Cheats
- Cruel to animals
- Concern for others
- Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- Complains
- Cries easily, feelings are easily hurt
- Dawdles, procrastinates, wastes time
- Difficulties with parent’s paramour/new marriage/new family
- Dependent, immature
- Developmental delays
- Disrupts family activities
- Disobedient, uncooperative, refuses, noncompliant, doesn’t follow rules
- Distractible, inattentive, poor concentration, daydreams, slow to respond
- Dropping out of school
- Drug or alcohol use
- Eating – poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- Exercise problems
- Extracurricular activities interfere with academics
- Failure in school
- Fearful
- Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- Fire setting
- Friendly, outgoing, social
- Hypochondriac, always complains feeling sick
- Immature, “clowns around”, has only younger playmates
- Imaginary playmates, fantasy
- Independent
- Interrupts, talks out, yells
- Lacks organization, unprepared
- Lacks respect for authority, insults, dares, provokes, manipulates
- Learning disability
- Legal difficulties – truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- Likes to be alone, withdraws, isolates
- Lying
- Low frustration tolerance, irritability
- Mental retardation
- Moody
- Mute, refuses to speak
- Nail biting
- Nervous
- Nightmares

- Need for high degree of supervision at home over play/chores/schedule
- Obedient
- Obesity
- Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- Oppositional, resists, refuses, does not comply, negativism
- Prejudiced, bigoted, insulting, name calling, intolerant
- Pouts
- Recent move, new school, loss of friends
- Relationships with brothers/sisters or friends/peers are poor – competition, fights, teasing/provoking, assaults
- Responsible
- Rocking or other repetitive movements
- Runs away
- Sad, unhappy
- Self-harming behaviors – biting or hitting self, head banging, scratching self
- Speech difficulties
- Sexual – sexual preoccupation, public masturbation, inappropriate sexual behaviors
- Shy, timid
- Stubborn
- Suicide talk or attempt
- Swearing, blasphemes, bathroom language, foul language
- Temper tantrums, rages
- Thumb sucking, finger sucking, hair chewing
- Tics – involuntary rapid movements, noises, or work productions
- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Underactive, slow-moving or slow-responding, lethargic
- Uncoordinated, accident-prone
- Wetting or soiling the bed or clothes
- Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics:

- _____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it? _____

This is strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.