Child/Family Intake Form:

Date:_____

Client Name: _____ Date of Birth: _____

Parent/Guardian Names:_____

Names and Ages of other Family Members:

Main Contact Phone#:_____ Email:_____

Address: _____

Presenting Problem:

_____

_____

_____

_____

How long have you had these issues, when did they first begin?

_____

_____

School History:

Pre-K _____

Elemenary _____

_____

Middle School _____

Which of the following gifted traits are your child displaying?

	Mild	Medium	Extreme
Anxiety	_____	_____	_____
Depression	_____	_____	_____
Social Anxiety	_____	_____	_____
Emotional Meltdowns	_____	_____	_____
Extreme Sensitivity	_____	_____	_____
Social Difficulty/Isolation	_____	_____	_____
Difficulty Sleeping	_____	_____	_____
Picky Eater	_____	_____	_____
Lack of Focus	_____	_____	_____

Executive Functioning Issues	_____	_____	_____
Aggression	_____	_____	_____
Difficulty with Transitions	_____	_____	_____
Panic Attacks	_____	_____	_____
Extremely Stubborn	_____	_____	_____
Expressing suicidal thoughts	_____	_____	_____
Difficulty controlling anger	_____	_____	_____
Sensory Issues	_____	_____	_____
Lack of Motivation	_____	_____	_____
Difficulty Organizing Self	_____	_____	_____
Difficulty with Self-Management (time, things, emotions)		_____	_____
Rigid/Black and White Thinker	_____	_____	_____
Perfectionism	_____	_____	_____
Underachievement	_____	_____	_____

Which of the following *stressors* has your child experienced?

	In past Month	In past Year	Sometime
Moving Schools	_____	_____	_____
Moving Houses	_____	_____	_____
Divorce in Family	_____	_____	_____
Death of a loved one	_____	_____	_____
Other Significant Loss (pet, etc)	_____	_____	_____
Friendship disruption	_____	_____	_____
Significant health problems	_____	_____	_____
Other significant changes or stressors	_____	_____	_____

Please Explain: _____

_____

Does your child express any suicidal thoughts or statements? _____

Is your child exploring their gender identity? What pronouns do they use?

_____

Treatment History (prior Counseling; Occupational Therapy; Other Therapy; Assessments)

Please list any prior treatment experience your child has had.

Name:_____ Type of Treatment: _____

Dates:_____ Length of treatment:_____

Reason for Treatment:_____

Outcome: _____

Name:_____ Type of Treatment: _____

Dates: _____ Length of treatment:_____

Reason for Treatment:_____

Outcome: _____

Medical History

Please list any medical conditions, past or present, that affect your child.

_____

_____

_____

Family HIstory

Has anyone in the family ever been diagnosed with any mental health condition (e.g. depression, anxiety, Bipolar, etc?)

_____

Substance Abuse History:

Is substance abuse a problem in any extended family members? (including illegal drugs, alcohol, marijuana)

_____

_____

_____

History of Abuse of Trauma:

Please describe any past experiences related to trauma (accidents, medical interventions, broken limbs, violence, etc and age of child at the time)

_____

_____

_____

Social History:

What sports, clubs or hobbies does the child participate in? _____

_____

_____

_____

What is your child's friend network?_____

Please describe the current living situation (which family members live together?)

_____

_____

What additional resources does the family have for emotional support? (Circle as many as apply)

Grandparents	Community Org.	Coworkers	Spiritual community	
Extended Family	Close Friends	Self-help group	Therapist	Neighbor

Others_____

What do you think are your family's Strengths and Challenges?

Strengths	Challenges
_____	_____
_____	_____
_____	_____

Is there anything else that you think is important for me to know about your child at this time?

_____

_____

_____

What do you hope will change as a result of the therapy services your child receives?

_____

_____

_____

_____

_____