



CHILD INTAKE FORM

Child's Full Name: _____ SSN: _____
 Date of Birth: _____ Gender: Male Female
 Referred by (Name/Agency): _____
 Primary Care Physician: _____ Phone: _____
 School: _____ Grade: _____
 Mother's Name: _____ SSN: _____
 Father's Name: _____ SSN: _____
 Child's Address: _____

Home Phone: _____ day/evening OK to leave msg? Yes No
 Work Phone: _____ day/evening OK to leave msg? Yes No
 Cell Phone: _____ day/evening OK to leave msg? Yes No

Child lives with:

Both Parents Mother only Father only
 Both Parents but separate houses Parent and Step Parent Other: _____

List names and ages of all individuals, including parents, residing in the child's primary home:

Name: _____ Age: ___ Relationship to client: _____
 Name: _____ Age: ___ Relationship to client: _____
 Name: _____ Age: ___ Relationship to client: _____
 Name: _____ Age: ___ Relationship to client: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Phone #: _____
 Ins. Co. Address: _____
 Subscriber's Name: _____ Subscriber Birthdate: _____
 ID #: _____ Group/Plan #: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Phone #: _____
 Ins. Co. Address: _____
 Subscriber's Name: _____ Subscriber Birthdate: _____
 ID #: _____ Group/Plan #: _____

REASON FOR VISIT

Briefly describe your primary concerns and why you have brought your child to the office:

FAMILY SITUATION

Relationship Status of Parents:

Cohabiting Married Separated Divorced Widowed Remarried (circle Mother, Father, or Both)

Mother's Ethnic Background: _____

Father's Ethnic Background: _____

Mother's Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

Father's Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

FAMILY HISTORY

List any *immediate or extended family members* with a history of concerns in the areas listed below. Please indicate their relationship to the child and provide more detailed information, such as specific diagnosis. There is additional space on the final page if needed. .

Chronic Physical Health Issues

Past: _____

Present: _____

Mental Health Concerns

Past: _____

Present: _____

Learning and/or Attention Concerns

Past: _____

Present: _____

Developmental Delay and/or Autism Spectrum Disorders

Past: _____

Present: _____

Drug/Alcohol Dependence or Abuse

Past: _____

Present: _____

Physical/Sexual Abuse and/or Neglect

Past: _____

Present: _____

Domestic Violence

Past: _____

Present: _____

CHILD'S MEDICAL HISTORY

How is your child's general health? Excellent Good Fair Poor

When was your child's last comprehensive medical evaluation? _____

List any serious illnesses for which your child required hospitalization or surgical operation:

Illness: _____ Year: ____ Doctor/Hospital: _____

Illness: _____ Year: ____ Doctor/Hospital: _____

Illness: _____ Year: ____ Doctor/Hospital: _____

Is your child currently taking any medications/supplements/vitamins? Yes No

Medication: _____ Dosage: _____ Date Started: _____ Prescriber: _____

Medication: _____ Dosage: _____ Date Started: _____ Prescriber: _____

Medication: _____ Dosage: _____ Date Started: _____ Prescriber: _____

Supplement/Vitamin: _____ Dosage: _____ Date Started: _____

Supplement/Vitamin: _____ Dosage: _____ Date Started: _____

List previous or current counseling, substance abuse services, psychiatric services, hospitalizations for mental health reasons, or psychological, speech/language, or occupational therapy assessment or services.

Service: _____ Year Started: _____ Currently receiving services? Yes No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? Yes No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? Yes No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? Yes No

Doctor/Therapist/Agency: _____

Please check whether your child currently has or has ever had any of the following:

Attention/Educational Issues	Developmental/Medical Issues	Emotional/Behavioral Issues
<input type="checkbox"/> Inattention	<input type="checkbox"/> Speech delay/problems	<input type="checkbox"/> Verbal aggression/defiance
<input type="checkbox"/> Organizational difficulties	<input type="checkbox"/> Fine/Gross motor delay	<input type="checkbox"/> Difficulty managing anger
<input type="checkbox"/> Academic delays/concerns	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Physically aggressive
<input type="checkbox"/> Memory concerns	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Sexualized behavior
<input type="checkbox"/> Peer conflict/bullying	<input type="checkbox"/> Bedwetting/bowel problems	<input type="checkbox"/> Low self-esteem
	<input type="checkbox"/> Head injury/concussion	<input type="checkbox"/> Depressed mood/withdrawn
Stresses/Trauma	<input type="checkbox"/> Frequent stomachaches	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Family issues/conflict	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Witness to domestic violence	<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> Ritualistic/Repetitive behaviors
<input type="checkbox"/> Multiple moves	<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Irritability
<input type="checkbox"/> Deaths or losses	<input type="checkbox"/> Self-injurious behavior	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Chronic illness in family		<input type="checkbox"/> Disturbing thoughts
<input type="checkbox"/> History of sexual abuse		<input type="checkbox"/> Feelings of hopelessness
<input type="checkbox"/> History of physical abuse		<input type="checkbox"/> Extreme fears
<input type="checkbox"/> History of emotional abuse		<input type="checkbox"/> Running away
<input type="checkbox"/> History of neglect		<input type="checkbox"/> Suicidal thoughts/attempts
<input type="checkbox"/> Legal issues		<input type="checkbox"/> Drug/alcohol use

Thank you for providing this information.

Bring this completed form to the initial appointment, and please attach a current photo of your child.

Additional comments/family history: