Child Intake Form

Identification Information: Date: ______________________________________

Child's Name: _________________________________ Age: ________ DOB: _____________

Race: White Black African American American Indian Alaska Native Other:___________

Social Security Number: ___________________________________

Child's Primary Address: ____

City: ______________________________ State: _____________ Zip: ___________________

Telephone Number: ____

School: ______________________________ Grade: ______ Teacher: ___________________

It is customary NewSong practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail, please provide an alternate mailing address here: ____

____

Guardian's Name (s): ____

Relationship: ____

Guardian's contact phone number: ____

Email:____

With whom does the child presently reside? ____

Emergency Contact Information (other than parents/guardian)

Name: ____ Relationship: __________________

Phone:_____________________________________

I authorize release of information to this emergency contact individual(s) as needed for emergency purposes: yes____ no _____

FATHER

Name: ____ Age: ________ DOB: _______________

Race: White Black African American American Indian Alaska Native Other:___________

Address: ___________________________________ City: ______________________ State: ____
Zip: __________ Phone: (H) ________________ (C) ________________ (W) _______________

Email: _________________________________

Preferred method of contact: **Phone** or **Email**

Which best describes you: Employed Disabled Student

Employer: ____ Occupation: __________________
Gross Annual Income (before taxes) $ __________________________________

Marital Status (circle one): **Single** **Married** (yrs.___) **Divorced** **Widowed** **Separated**
Spouse / Significant Other: ____

Age when first married (if married): _____________ Age at birth of child: ________________
Has the child's father been previously married? **Yes** **No**

MOTHER

Name: ____ Age: ________ DOB: _______________

Race: White Black African American American Indian Alaska Native Other:___________

Address: ___________________________________ City: ______________________ State: ____
Zip: __________ Phone: (H) ________________ (C) ________________ (W) _______________

Email: _________________________________

Preferred method of contact: **Phone** or **Email**

Which best describes you: Employed Disabled Student

Employer: ____ Occupation: __________________
Gross Annual Income (before taxes) $ __________________________________

Marital Status (circle one): **Single** **Married** (yrs ____) **Divorced** **Widowed** **Separated**
Spouse / Significant Other: ____

Age when first married (if married): _____________ Age at birth of child: ________________
Has the child's mother been previously married? **Yes** **No**

Siblings / Other Household Members:

Name:	Relationship:	Age/Gender:	School/Grade:
___________________________	______________	______________	___________
___________________________	______________	______________	___________
___________________________	______________	______________	___________
___________________________	______________	______________	___________
___________________________	______________	______________	___________

What kind of relationship does the client have with his/her siblings? **GOOD** **FAIR** **POOR**

What kind of relationship does the mother have with this child? **GOOD** **FAIR** **POOR**

What kind of relationship does the father have with this child? **GOOD** **FAIR** **POOR**

How did the mother feel when this child was born? ____________________________________
____

How do the parents communicate love to the child? ____________________________________
____
____

What are the main methods of discipline used at home and how effective have they been?
____

Has the child ever experienced any type of abuse? (physical/sexual/verbal) If so, please

describe: ____
____

Custody Arrangements: *(if applicable)*

Primary Residential Parent: ____

Visitation Schedule:

Client is with ___________________________________ on ____________________

Client is with ___________________________________ on ____________________

According to the Parenting Plan, who is authorized to make health care decisions? (circle one)

Father **Mother** **Joint** **Other (please specify): ____________________**

*** Please provide NewSong Counseling Center with a copy of the custody arrangement.**

MEDICAL/MENTAL HEALTH INFORMATION:

Medical conditions or illnesses: ____

Accidents or injuries: ____

Hospitalizations: ____

Child's Current Pediatrician: ____

When was your last medical check-up? ____

Is the child currently on any medications? **YES** **NO**
If yes, please list all of the medication(s) he/she is currently taking.

____

____

Preferred Pharmacy ____

Has the child experienced any of the following? (please circle all that apply)

Surgery	Asthma	High fever	Convulsions/seizures	eye problems
Allergies	Hearing Problems		Loss of consciousness	Other

Describe Allergies: ____

Explain "other": ____

How would you rate the child's overall health? (please circle)

GOOD 10 9 8 7 6 5 4 3 2 1 POOR

Briefly describe significant family events which the child has experienced: (divorce, remarriage, death, domestic violence)

____

____

How does the child interact with family members? ____________________________

____

Please indicate any of the following disorders which any of the client's blood RELATIVES have had by checking the corresponding box:

	Mother	Father	Sister	Brother	Grandfather	Grandmother
ADHD/ADD						
Alcoholism						
Anemia						
Anxiety						
Asthma						
Cancer						
Depression						
Diabetes						
Drug Addiction						
Epilepsy						
Fears/Phobias						
Hepatitis						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Low Blood Pressure						
Manic Depression						
Obsession Compulsion with specific activities						
Psychiatric Treatment						
Stroke						
Veneral Disease						

DEVELOPMENTAL HISTORY:

Please describe the mother's pregnancy: ____

____

Were there any problems during the pregnancy of this child? **YES** **NO**

If yes, please describe: ____

During pregnancy, did the child's mother:

Smoke? **YES** **NO** Use alcohol? **YES** **NO**

Use street drugs? **YES** **NO** If yes, please list: ___________________________

How was/is the child's physical health from 0-12 years? **GOOD FAIR POOR**

Explain anything unusual: ____

How was/is the child's physical development from 0-12 years? **GOOD FAIR POOR**

Explain anything unusual: ____

How was/is the child's emotional development from 0-12 years? **GOOD FAIR POOR**

Explain anything unusual: ____

Circle any of the following which did NOT occur in a typical developmental time period.

Smiled Sat without support Walked alone Spoke first word

Used two- or three-word sentences Completely weaned Started toilet training

Completely toilet trained Completely dressed him/herself

CHILD'S ACADEMIC HISTORY:

Does the child enjoy school? **YES NO**

Does the child have any learning challenges? If yes, please describe: ____________________

____

Has the child had any special testing or evaluation? If yes, please describe: ________________

____

List any special services that the child is currently receiving: (tutoring, speech therapy, etc.)

____

What kind of grades does the child typically receive in school?

ABOVE AVERAGE AVERAGE BELOW AVERAGE

Has the child ever repeated a grade? If yes, specify which grade ______________________

Is the child involved in extra-curricular activities? (band, sports, etc.) If yes, please describe:

____

How many close friends does the child have? ____

How does the child relate to his/her classmates? **GOOD FAIR POOR UNSURE**

How does the child relate to his/her teachers? **GOOD FAIR POOR UNSURE**

Has the child experienced any of the following problems at school? (please circle all that apply)

Gang influence	Incomplete Homework	Behavior Problems	Poor Attendance
Suspension	Exposure to drugs/alcohol	Detention	Fighting

CHILD'S PRESENT PSYCHOLOGICAL STATUS:

Does the child experience any of the following personal habits? (please circle all that apply.)

Nail-biting	Temper tantrums	Nightmares	Thumb-sucking	Bedwetting
Fears	Phobias	Running away	Other	

Explain "other": ____

How would you describe the child's personality? ____
____

Please list the child's hobbies or other interests. ______________________________________
____

Does the child have any pets? If yes, what kind(s)? ____________________________________

Is there anything currently bothering the child, causing worry or stress? If yes, please explain?
____

Has the child ever experienced any serious personal, emotional losses? Please describe.
____

How would you rate the child' temper? **SHORT MEDIUM LONG**

Has the child ever made statements of want to hurt self or someone else? **YES NO**

PRESENTING ISSUES:

Please describe any of the following concerns which the child may have and length of time the issue has been present:

Behavior ____

Relationships ____

Activities ____

Academics ____

Family Situation ____

Development ____

Habits ____

Gender Confusion ____

Other ____

ADDITIONAL INFORMATION:

Has the child previously been in counseling? **YES** **NO**

If yes — Dates and Provider: ____

Child's response to treatment: ____
____

Why are you currently seeking counseling for the child? ____________________________
____

Who referred you to NewSong Counseling Center? _________________________________

Please tell me anything else that you would like for me to know about the child. (use back of page if needed)
____
____
____
____
____
____
____

Guardians' Signature:_________________________________ **Date:** __________________