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# NEW CLIENT INTAKE FORM

**Child, 12 years of age and younger**

**Please complete one form for each child in the family, and sign and date where indicated.**

Name of child_____ DOB ___/___/___ Age _____

Gender Pronouns_____

Name of person completing this form: _____

Preferred Phone _____ _ □CellPh □HmPh Other: _____

Email _____ Preferred Communication □Cell □HmPh □Email

Okay to leave a message on my: □ Home □Cell □ Work number □ Other

Residential Address _____ City _____ Zip _____

May I send mail to this address? Yes No

Email _____May I use email to confirm appointments? Yes No

School: _____ Grade: _____

Emergency Contact _____Relationship_____

Emergency Contact Phone_____

**Has your child had prior counseling or psychiatric treatment? ____ No ___Yes**
**If yes:**

**When? _____ Where? _____**

**Reason for and length of treatment:_____**

***Check one:*** **Therapy was ____ helpful ___ not helpful. Please explain.**

_____

_____

_____

_____

**MEDICAL / PHYSICAL HEALTH**

**Name, address and phone number of your child's primary care physician:**

_____

**Date of your child's last physical exam: _____**

**Has your child been under a physician's care for any reason in the last five years? If yes, please explain.**

_____

_____

_____

_____

**PLEASE CHECK BEHAVIORS AND SYMPTOMS YOUR CHILD <u>CURRENTLY EXPERIENCES</u>**

| | | |
|---|---|---|
| ____Aggression | ____Fatigue | ____Panic attacks |
| ____Alcohol use | ____Flashbacks | ____Phobias/fears |
| ____Anger | ____Grief | ____Poor judgment |
| ____Anxiety | ____Hallucinations | ____Self-esteem problems |
| ____Chronic pain | ____Heart palpitations | ____Sexual difficulties |
| ____Compulsive behavior | ____High blood pressure | ____Sleep problems |
| ____Concentration problems | ____Hopelessness | ____Social withdrawal |
| ____Cyber addiction | ____Hyperactivity | ____Suicidal thoughts |
| ____Depression | ____Impulsivity | ____Thoughts disorganized |
| ____Disorientation | ____Irritability | ____Trembling |
| ____Distractibility | ____Loneliness | ____Unresolved trauma |
| ____Dizziness | ____Memory impairment | ____Worrying |
| ____Drug dependence | ____Mood swings | ____Other (specify):_____ |
| ____Eating disorder | ____Obsessive thoughts | |

**For any of the items checked, please provide additional information regarding your symptoms. How often and severe are your symptoms? Do want to share additional information?**

_____

_____

_____

_____

**PLEASE CHECK BEHAVIORS AND SYMPTOMS YOUR CHILD**
**HAS EXPERIENCED IN THE PAST**

| | | |
|---|---|---|
| ____Aggression | ____Fatigue | ____Panic attacks |
| ____Alcohol use | ____Flashbacks | ____Phobias/fears |
| ____Anger | ____Grief | ____Poor judgment |
| ____Anxiety | ____Hallucinations | ____Self-esteem problems |
| ____Chronic pain | ____Heart palpitations | ____Sexual difficulties |
| ____Compulsive behavior | ____High blood pressure | ____Sleep problems |
| ____Concentration problems | ____Hopelessness | ____Social withdrawal |
| ____Cyber addiction | ____Hyperactivity | ____Suicidal thoughts |
| ____Depression | ____Impulsivity | ____Thoughts disorganized |
| ____Disorientation | ____Irritability | ____Trembling |
| ____Distractibility | ____Loneliness | ____Unresolved trauma |
| ____Dizziness | ____Memory impairment | ____Worrying |
| ____Drug dependence | ____Mood swings | ____Other (specify):_____ |
| ____Eating disorder | ____Obsessive thoughts | |

**For any of the items checked, please provide additional information. When did your child experience these symptoms? Can you identify a cause of these symptoms? How often and severe were they? If the symptoms stopped, can you identify why they did so?**

_____

_____

_____

_____

## Alcohol and Substance Use

**Has your child ever been treated for alcohol or drug dependence/abuse?**
**__Yes __No**

**Has your child ever felt like you should cut down on alcohol or other drug use?**
**__Yes __No**

**Has a friend or relative ever discussed concerns about your child's alcohol or drug use? __Yes __ No**

**Is there a history of problems with alcohol or drug use in your family?**
**__Yes __ No**

**Has your child received help for drug or alcohol dependency? ___ No __Yes**
**If yes:**

**When? _____ Where?_____**

***Check one:*** **Treatment was ___ helpful ___ not helpful. Please explain:**

_____

## MEDICATION

| Current Prescribed Medications | Dose | Frequency | Purpose and Side Effects |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Please describe your child's experience growing up. Describe your child's relationship with his/her parents and siblings. What is your child's birth-order position in the family?**

_____

_____

_____

_____

**What is your child's role in his/her family?**

_____

_____

_____

_____

**What stories about your child are told in the family?**

_____

_____

_____

_____

**Please describe your child's medical history.**

_____

_____

_____

_____

**Please describe your child's mental health history.**

_____

_____

_____

_____

**Please describe your child's developmental history. Did/Does he/she struggle with meeting developmental timelines and/or a learning difficulty?**

_____

_____

_____

_____

**How does your child perform academically? How you feel about this level of performance?**

_____

_____

_____

_____

**Please describe your child's social behaviors and history of social relationships. Does your child make friends easily? Does your child struggle with peer relationships?**

_____

_____

_____

_____

**Does your child have a history of behavior problems? Does he/she continue to struggle with behavior problems? If so, please describe.**

_____

_____

_____

_____

**Has your child experienced trauma? If so, please describe.**

_____

_____

_____

_____

**What upsets your child?**

_____

_____

_____

_____

**How does your child cope when he/she is upset?**

_____

_____

_____

_____

**Who does your child go to when he/she is upset?**

_____

_____

_____

_____

**What activities does your child do for fun?**

_____

_____

_____

_____

**What does your child do to relax and/or care for him/herself?**

_____

_____

_____

_____

**Is there anything else you think would be helpful for me to know about your child or his/her situation?**

_____

_____

_____

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**By signing below, I confirm the information I provided on this document to be complete and truthful to the best of my knowledge.**

| _____ | _____ | _____ |
|---|---|---|
| **Client Name (please print)** | **Signature of Client (or authorized representative)** | **Date** |

| _____ | _____ | _____ |
|---|---|---|
| **Form completed by (please print)** | **Signature** | **Date** |