Capital Valley Counseling Associates, Inc.

Child Intake Forms

Contact & General Information

Child's Name _____ DOB: _____

Mother's Name: _____

Address _____ City/Town _____ Zip _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell) _____

May we leave a message at the Home phone? _____ Work phone?_____ Cell phone? _____

Email address: _____May we contact you by Email?_____

Father's Name: _____

Address _____ City/Town _____ Zip _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell) _____

May we leave a message at the Home phone? _____ Work phone?_____ Cell phone? _____

Email address: _____May we contact you by Email?_____

Emergency Contact:_____Phone_____

How did you find out about us and our services? _____

Who has Legal custody?_____Physical custody?_____

What is the child's schedule or visitation plan?_____

_____

Please list date(s) and provider(s) of any prior counseling or other treatment: _____

_____

Has your child had any Psychological Testing?_____When and where?_____

_____

For what reason?_____

Has your child had a Neurological examination?_____When and where?_____

_____

For what reason?_____

Client Questionnaire

A. Why are you seeking counseling at this time? _____

_____

_____

B. What do you hope to achieve through counseling? _____

_____

_____

C. Please rate how upsetting the above concern(s) is/are right now:

____ Mildly Upsetting ____ Moderately Upsetting ____ Very Upsetting ____ Extremely Upsetting

D. When did the problem(s) begin (give dates if possible)? _____

_____

E. In what ways have you tried to solve the problem(s), and who or what has been helpful?

_____

_____

F. Please list the members of your child's family.

	Name	Age	Marital status	Occupation and/or education	If deceased, age at death/cause
Child					
Mother					
Spouse/ partner					
Siblings					
Father					
Spouse/ partner					
Siblings					
Others living					
with family					

G. Is your family currently involved with any social service or legal or other agency? ___No ___Yes. If yes please explain:_____

_____

_____

_____

H. Check any of the following that apply to you (or your child) and indicate the person involved:

EVENT	CHILD	FAMILY MEMBERS	DATE
Divorce			
Financial Trouble			
Job/School Problems			
Abuse: emotional			
Abuse: physical			
Abuse: sexual			
Domestic Violence			
Suicide thoughts/attempts			
Depression			
Anxiety			
Death of loved one (who?)			
Alcoholism			
Addictions (Describe)			
Physical/medical conditions			
Physical/medical conditions			
Physical handicap			
Other			

I. What are your child's hobbies/leisure activities? _____

_____

J. Is there anything else you want us to know about your child?_____

_____

_____

_____

K. Do you have weapons in your home?_____ If so, where are they kept?_____

_____

Medical Information

Name _____ Sex _____ Age ____
Height _____ Weight now _____ One year ago _____
Concerning weight loss or gain?_____

Current Prescribed Medications	Dosage	Prescriber's name

Substance Use	Current Amount	Past Amount
Cigarettes		
Caffiene		
Alcohol		
Street Drugs		
Pain Relief Meds		
Other Meds		

Surgeries / Hospitalizations _____

_____

_____

Other Medical Concerns/Conditions:_____

_____

_____

_____

Primary Care Provider _____ Date of last visit _____

Psychiatrist or Psychiatric Nurse Practioner_____

Child Checklist of Concerns

Many concerns can apply to both children and adults. Mark all of the items that apply to your child below. Circle descriptions that apply where there are multiple examples. Feel free to add any others at the end under "Any other characteristics."

☐ Abuse – perpetrator of abuse.
☐ Abuse – victim of abuse.
☐ Addictions – gambling, screens/Internet/video games, pornography, substances.
☐ Aggression – physical toward people.
☐ Aggression – physical toward property.
☐ Anger, hostility, arguing, irritability.
☐ Anxiety, nervousness.
☐ Argues, "talks back," defiant.
☐ Bizarre thoughts.
☐ Bullies/intimidates, teases, is bossy to others, instigates conflict, provokes others.
☐ Cheating, lying, deceitfulness, dishonest.
☐ Compulsions.
☐ Concern for others, empathy.
☐ Concern regarding drug or alcohol use/abuse.
☐ Confusion.
☐ Cruel to animals.
☐ Cries easily, feelings are easily hurt.
☐ Dawdles, procrastinates, wastes time.
☐ Delusions (false ideas).
☐ Depression, low mood, sadness, feelings of emptiness or hopelessness, feelings of failure.
c Developmental delays.
☐ Difficulties with parent's partner/new marriage/new family.
☐ Disobedient, uncooperative, doesn't follow rules.
☐ Disrupts family activities.
☐ Divorce, separation.
☐ Dropping out of school.
☐ Fatigue, tiredness, low energy.
☐ Fears, phobias.
☐ Fire setting.
☐ Friendships / social issues.
☐ Gender identity issues.
☐ Grieving, mourning, deaths, losses, divorce.
☐ Guilt.
☐ Headaches, stomach aches, other kinds of pains.
☐ Health, illness, medical concerns, physical problems.
☐ Impulsiveness, loss of control, outbursts, interrupts, talks out.
☐ Inattention, poor concentration, distractibility.
☐ Interpersonal conflicts.
☐ Intolerant of ethnic/religious/gender/sexual orientation or cultural differences.
☐ Irresponsibility.

☐ Irritable.
☐ Judgment problems, risk taking.
☐ Lacks respect for authority.
☐ Learning disability.
☐ Legal difficulties – please specify_____
☐ Loneliness.
☐ Low frustration tolerance.
☐ Lying.
☐ Memory problems.
☐ Menstrual problems, PMS.
☐ Mood swings.
☐ Motivation, laziness, procrastination.
☐ Mute, refuses to speak.
☐ Need for high degree of supervision at home with play/chores/schedule.
☐ Nightmares.
☐ Obsessions, compulsions (thoughts or actions that repeat themselves).
☐ Oppositional.
☐ Overactive, restless, hyperactive, out-of-seat behaviors, fidgety.
☐ Overly dependent, immature for age.
☐ Oversensitivity to rejection.
☐ Panic or anxiety attacks.
☐ Perfectionism.
☐ Pessimism.
☐ Physical complaints -headaches, stomach aches, other pains.
☐ Pouts.
☐ Poor motivation, laziness.
☐ Procrastinate, waste time.
☐ Relationship problems.
☐ Rocking or other repetitive movements.
☐ Runs away.
☐ School problems.
☐ Self-centeredness.
☐ Self-esteem issues.
☐ Self-harming behaviors – cutting, biting or hitting self, head banging, hair pulling, scratching self.
☐ Self-neglect, poor self-care – grooming, hygiene.
☐ Sexual – sexual preoccupation, inappropriate sexual behaviors.
☐ Shyness, oversensitivity to criticism, timid.
☐ Sleep problems – too much, too little, insomnia, nightmares.
☐ Somatic/illness/pain complaints, feeling sick frequently/always.
☐ Speech difficulties.
☐ Stubborn.
☐ Suicidal talk, gestures, attempts.
☐ Suspiciousness.
☐ Swearing, profanity.
☐ Teased, picked on, bullied.

- ☐ Temper problems, self-control, low frustration tolerance.
- ☐ Threatening to others verbally, physically, property.
- ☐ Tics – involuntary rapid movements, noises, or word productions.
- ☐ Truant, school avoidance.
- ☐ Uncoordinated, accident-prone.
- ☐ Under-active, slow-moving or slow-responding, lethargic.
- ☐ Weight and diet issues.
- ☐ Wetting or soling the bed or clothes.
- ☐ Withdrawn, isolate from others.

Any other concerns or comments?_____