Capital Valley Counseling Associates
Child Intake Forms

Contact & General Information

Child's Name _____ DOB: _____

Address _____ City/Town _____ Zip_____

Mother Name: _____ Address (if different from above) _____

_____ City/Town _____ Zip _____

Mother's Phone (Home) _____ (Work) _____ (Cell) _____

May we leave a message at (circle one): Home: Yes / No Work: Yes / No Cell: Yes / No

Father's Name: _____ Address (if different from above) _____

_____ City/Town _____ Zip _____

Father's Phone (Home) _____ (Work) _____ (Cell) _____

May we leave a message at (circle one): Home: Yes / No Work: Yes / No Cell: Yes / No

Who has legal custody? _____ Physical custody? _____

What are visitation agreements? _____

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

_____

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

_____

_____

_____

Does your child have a history of:

Substance Abuse? (Describe) _____

_____

Physical Aggression? (Describe) _____

_____

Legal Issues? (Describe) _____

_____

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. Check any of the following that apply to your child and indicate the person involved:

Event	**Child**	OR	**Family Member(s)**	**Date**
Divorce	_____		_____	_____
Financial Trouble	_____		_____	_____
Job/School Problem	_____		_____	_____
Abuse (emotional, physical, or sexual)	_____		_____	_____
Alcohol or Drug Problem	_____		_____	_____
Domestic Violence	_____		_____	_____
Depression	_____		_____	_____
Suicide or Suicide Attempts	_____		_____	_____
Death in the Family	_____		_____	_____

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

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

Child Checklist of Concerns

Person completing this form: _____

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 to other.
- ☐ Abuse – Victim of abuse – physical or sexual.
- ☐ Addiction – screens/Internet/technology, gambling, pornography.
- ☐ Aggression – physical toward people.
- ☐ Aggression – physical toward property.
- ☐ Anger, hostility, irritability.
- ☐ Anxiety/nervousness
- ☐ Argues, "talks back," smart-alecky, defiant
- ☐ Bizarre thoughts.
- ☐ Bullies/intimidates, teases, is bossy to others, provokes/instigates conflict.
- ☐ Complains
- ☐ Concern regarding drug or alcohol use/abuse.
- ☐ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- ☐ Confusion
- ☐ Cries easily, feelings are easily hurt
- ☐ Cruel to animals
- ☐ Dawdles, procrastinates, wastes time
- ☐ Decision making difficulties, indecisive.
- ☐ Delusions (false ideas.)
- ☐ Dependent, immature
- ☐ Depression, low mood, sadness, feelings of failure, emptiness, failure.
- ☐ Developmental delays
- ☐ Difficulties with parent's partner/new marriage/new family
- ☐ Disobedient, uncooperative, doesn't follow rules
- ☐ Disrupts family activities
- ☐ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ☐ Divorce, separation.
- ☐ Dropping out of school.
- ☐ Fatigue, tired, low energy.
- ☐ Fears/phobias.
- ☐ Fire setting
- ☐ Gender identity issues.
- ☐ Grief, mourning – death, divorce.
- ☐ Guilt
- ☐ Health/medical illness/concerns, physical problems.
- ☐ Hypochondriac, frequently/always complains of feeling sick.
- ☐ Imaginary play.
- ☐ Immature, "clowns around," has only younger playmates
- ☐ Impulsive – loss of control, interrupts, talks or acts out without thinking.
- ☐ Inattention, poor concentration, easily distracted.
- ☐ Intolerant of cultural, racial, ethnic differences.
- ☐ Irresponsibility

- ☐ Judgment problems/risk taking.
- ☐ Lacks concern for others – little to no empathy.
- ☐ Lacks respect for authority, provokes, manipulates.
- ☐ Learning disability.
- ☐ Legal difficulties.
- ☐ Loneliness.
- ☐ Low frustration tolerance, irritability
- ☐ Lying
- ☐ Lying/dishonesty.
- ☐ Memory problems.
- ☐ Menstrual problems, PMS.
- ☐ Mental retardation
- ☐ Mood swings.
- ☐ Motivation, laziness, procrastination.
- ☐ Mute, refuses to speak.
- ☐ Need for high degree of supervision at home over play/chores/schedule.
- ☐ Nightmares
- ☐ Obsessions/compulsions (thoughts or actions that repeat themselves.)
- ☐ Oppositional.
- ☐ Overactive, restless, hyperactive, out-of-seat behaviors, fidgety.
- ☐ Oversensitivity to rejection.
- ☐ Panic/anxiety attacks.
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Physical pain/complaints – headaches, stomach aches, other pains.
- ☐ Pouts
- ☐ Relationship issues with brothers/sisters or friends/peers – competition, fights, teasing/provoking, assaults.
- ☐ Rocking or other repetitive movements
- ☐ Runs away.
- ☐ School problems – social or academic concerns.
- ☐ Self-centeredness.
- ☐ Self-esteem issues.
- ☐ Self-harming behaviors – cutting, biting or hitting self, head banging, scratching self, hair pulling.
- ☐ Self-neglect, poor self-care, grooming, hygiene.
- ☐ Sexual – sexual preoccupation, inappropriate sexual behaviors.
- ☐ Speech difficulties
- ☐ Stubborn
- ☐ Suicidal thoughts, talk, attempts.
- ☐ Swearing, profanity.
- ☐ Teased, picked on, victimized, bullied
- ☐ Temper problems, self-control, low frustration tolerance.
- ☐ Threats, violence - threatening to others – physical, verbal, property.
- ☐ Thumb sucking, finger sucking, hair chewing.
- ☐ Tics – involuntary rapid movements, noises, or word productions
- ☐ Truant, school avoiding
- ☐ Uncoordinated, accident-prone.
- ☐ Underactive, slow-moving or slow-responding, lethargic.
- ☐ Wetting or soiling the bed or clothes.
- ☐ Withdrawn, isolates self from others.

Any other characteristics:

☐ _____

☐ _____

Please look back over the concerns you have checked off and identify your primary concerns:

_____

_____

_____

Developmental History

Name of Child: _____ DOB: _____ Age: _____ Grade: _____

Name of Mother: _____ DOB: _____ Age: _____

Marital Status: _____ Education: _____ Occupation: _____

Name of Father: _____ DOB: _____ Age: _____

Marital Status: _____ Education: _____ Occupation: _____

Siblings:	Name	DOB	Age	Education
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Others Living with Family:

	Name	DOB	Age	Education
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

If you have **other** children under 18 who live outside of your home:
Who has legal custody? _____ Physical custody? _____

What are visitation agreements? _____

Is your family currently involved with any social service or legal or other agency? ____ No ____ Yes
If Yes, please explain: _____
_____
_____

How many times has the child moved? _____

Pregnancy and Birth:

1. a) During this pregnancy did the mother experience any unusual illness, condition, or accident such as German measles, RH incompatibility, false labor, etc.? If so, please describe:

_____

b) Was the mother taking any drugs during pregnancy? If yes, please list: _____

_____

2. Length of pregnancy: _____ Duration of labor: _____ Birth Weight: _____

   Were there any problems with delivery such as breech birth, Caesarian section, etc.? If so, please describe:

_____

3. Was the pregnancy planned? _____

Feeding:

Were there any feeding problems? If yes, please describe: _____
_____

Developmental:

At what age did the following occur:

Age of walking: _____ Age of talking: _____

Age of toilet training: _____ Dressed and undressed self: _____

Describe the infant's temperament: _____

Did the child have difficulty with strangers or separating from parents? _____

Were there any developmental problems or concerns? If yes, please explains: _____
_____

Medical History:

Describe accidents or operations the child has had: _____
_____
_____

Describe any hospitalizations: _____
_____

Were there any medical problems other than normal childhood illnesses? If yes, please explain:
_____

Were any of these illnesses followed by noticeable changes in the child's general behavior or in his/her speech? If so, please describe:
_____
_____

Have the child's eyes been examined? _____ Results: _____

Have the child's ears been examined? _____ Results: _____

Is the child under the care of a doctor? _____ Does he/she presently take medication? _____

Names of medications and dosages: _____

How long has the child taken the medications? _____

What was the child's reaction? _____

Child's physician: _____ Address: _____

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? _____

Educational History:

Did the child attend Nursery School? _____ Kindergarten? _____

School Attending? _____ Grade: _____ Teacher: _____

What are his/her usual grades in the following subjects?

Math: _____ Reading: _____ Spelling: _____

Grades Failed? _____ Grades Skipped? _____

Is the child frequently absent from school? _____ If yes, please explain: _____
_____

Does the child have an Individual Education Plan, or is he/she coded? _____

Daily Behavior:

Does your child have nightmares? _____

Does he/she have fears? _____

Does your child sleep well? _____ Eat well? _____

Does he/she tend to play alone, or with other children? _____

How does he/she get along with adults? _____

Is it difficult to discipline the child? _____ Explain as fully as possible: _____
_____
_____

Would you describe your child as basically happy or unhappy? _____

Does your child have difficulty in concentration? _____

What are his/her favorite play activities? _____

Additional comments on behavior: _____
_____

Describe relationships with mother, father, and siblings: _____
_____

Medical Information

Child's Name _____ Sex _____ Age _____
Height _____ Weight now _____ One year ago _____
Maximum weight (when?) _____ Weight you consider ideal _____
Current prescribed medications, dosage, and prescriber's name: _____
_____
_____
_____

Substance Use	Present Amount	Past Amount
Cigarettes	_____	_____
Caffeine	_____	_____
Alcohol	_____	_____
Street drugs	_____	_____
Pain relief (over the counter)	_____	_____
Other over the counter meds	_____	_____

Present Medical History
Allergies _____
Surgeries / Hospitalizations _____
_____
Primary Care Provider _____ Date of last visit _____

Check any of the following that apply to:

	Your child	Family Members – Who?
Depression	_____	_____
Anxiety	_____	_____
Alcoholism	_____	_____
Drug Addiction	_____	_____
Arthritis	_____	_____
Jaundice / Liver Disorder	_____	_____
High Blood Pressure	_____	_____
Heart Condition	_____	_____
Anemia	_____	_____
Chronic pain	_____	_____
Diabetes	_____	_____
Kidney Disease	_____	_____
Headaches	_____	_____
Lung Disorder	_____	_____
Stomach Ulcer	_____	_____
Cancer	_____	_____
Physical Handicap	_____	_____

Epilepsy	_____	_____
Other _____	_____	_____