Emergent Mental Health Services

Stephanie Rojas, LMHC

917-727-7896

Child/Family Intake Information Form

Please complete this confidential intake form to help me better understand your child and family. Thank you!

Identifying Information:

Child's Name: _____Child's DOB: _____ Age: _____

Form completed by (if someone other than client):_____

Current Grade: _____ School: _____

Child's Ethnicity: _____Religion: _____Language(s) Spoken in the Home: _____

Child's Address: _____Apt: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Name: _____ Parent's DOB: _____

Parent's Address: _____Parent's Phone Number: _____

Parent/Guardian Name: _____ Parent's DOB: _____

Parent's Address: _____ Parent's Phone Number: _____

Parent's Marital Status: __Single ___ Never Married ____Divorced ____Separated ____Widowed

Are parent's divorced or separated? _____

If yes, who has legal custody? _____

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ___Yes ___No
If yes, describe:

_____

_____

Stepparent's Name (s):_____Stepparent's Phone Number:_____

Child's Emergency Contact if Parent or Guardian is Not Able to Be Reached:

Name: _____ Phone Number: _____

Relationship to Child: _____

Referred to Therapy by: _____

Primary reason(s) for seeking services:
___Anger management ___Anxiety ___Depression ___Eating disorder ___Fear/phobias ___ Sexual concerns
___Sleeping problems ___Addictive behaviors ___Alcohol/drugs ___Inattention/Hyperactivity
___Trauma
___Other mental health concerns (specify):

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Quality of relationship with the client___
_____	____	_____	___poor ___average ___good
_____	____	_____	___poor ___average ___good
_____	____	_____	___poor ___average ___good
_____	____	_____	___poor ___average ___good

Others living in the household		Relationship	
_____	____	_____	___poor ___average ___good
_____	____	_____	___poor ___average ___good
_____	____	_____	___poor ___average ___good
_____	____	_____	___poor ___average ___good

Comments:
_____

_____

Medical Information:

Name of Current Pediatrician: _____

Phone Number of Pediatrician: _____

Date of Last Physical Exam: _____

Name of Psychiatrist (if applicable): _____

Previous Outpatient Therapist (if applicable): _____

Past Diagnosis (if applicable): _____

Please check off if your child has been treated for any of the following:
___Asthma ___Auto-immune disorder (specify): _____
___Cancer ___Diabetes ___Eating Disorder ___Epilepsy (seizures) ___Eye Problem (specify): _____
___Eye Problem (specify): _____ ___Headaches ___Heart Problem (specify): _____
___Head Injury ___HIV Infection ___Infections ___Sickle Cell or Trait ___Overweight/Obsesity
___Other Medical Illness (specify): _____

Family Medical History:
Has anyone in your family ever been treated for any of the medical problems listed above? What medical problems run in the family (Both Parent's Side)? List who and what illness:

_____

_____
_____

List Child's Current Medications (Prescribed and Over the Counter):

_____
_____

List Child's Allergies (medication, food, seasonal, etc):

_____
_____

List Child's History of Hospitalizations (both medical and psychiatric):

Hospital	**Date**	**Reason**
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Developmental History:</u>

Child's Weight at Birth: _____

___Vaginal Birth ___Cesarean Birth ___Full Term ___ Premature

Mother's Age at Child's Birth:_____ Cigarette use during Pregnancy: __Yes ___No
Mother's Age at Child's Birth:_____

Father's Age at Child's Birth:_____ Drug/Alcohol use during Pregnancy: ___Yes ___No
Father's Age at Child's Birth:_____

Planned Pregnancy: __Yes __No
How did you feel when you found out about your pregnancy or found out your partner was pregnant? Or how did you feel about your adoption? Or how did you feel about your surrogate's confirmation of pregnancy?

_____
_____

Complications during pregnancy ___ Yes ___ No
Describe: _____

Complications at birth ___Yes ___No
Describe: _____

Complications after birth: ____ Feeding Problems ____Post Partum Depression
____Relationship Problems ___Other: _____

<u>Childhood Developmental Milestones (write in age of achievement):</u>

Sitting Up: _____ Walking: _____ Talking Words: _____Talking Sentences: _____
Bowel/Bladder Control/Toilet Trained: _____

Child Adoption or Foster Care History:

_____
_____

School/Academic History:

Present School/Grade/Teacher(s): _____

Which subjects does the child enjoy in school?_____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

List Schools Attended since Pre-School (put city/state):

_____
_____
_____
_____
_____

Current Afterschool Program or Activities: _____

Special Education (note classification): _____

General Education, Self-Contained Classroom (12:1:1 or 8:1:1), or Integrated Co-Teaching (ICT):

_____

Services in School (speech, OT, PT, Counseling, etc): _____

History of being retained: _____

History of school suspension/expulsion: _____

Attendance problems: _____

Learning challenges: _____

Strengths:

_____

School Bullying:

_____

Feelings about School Work:
___Anxious ___Passive ___Enthusiastic ___Fearful ___Eager ___No expression ___Bored ___Rebellious ___Other (describe):

_____

Approach to School Work:
___Organized ___Industrious ___Responsible ___Interested ___Self-directed ___No initiative ___Refuses ___Does only what is expected ___Sloppy ___Disorganized ___Cooperative ___Doesn't complete assignments ___Other (describe):

_____

Performance in School (Parent's Opinion):
___Satisfactory ___Underachiever ___Overachiever
Other (describe):

_____

Child's Peer Relationships:
___Spontaneous ___Follower ___Leader ___Difficulty making friends ___Makes friends easily
___Long-time friends ___Shares easily
___Other (describe):

_____

Changes in Child's Behavior:

Have you noticed changes in the following behaviors/ areas in the last few weeks?
Sleep: ___ yes ___no
If Yes, Describe: _____
Where does your child sleep? _____
Appetite: ___ yes ___no
If Yes, Describe:

_____
Mood: ___ yes ___no
If Yes, Describe:

_____
Other changes:

_____
_____

Child/Adolescent Behavioral Patterns or Presenting Problems:

(Please circle all behaviors/symptoms/reasons for referral that apply):

Temper outbursts	Worried	Drug/Alcohol use
Impulsive	Bullying others	Phobic
Sexualized Language or	School trouble	Rocking of body
Behavior	Peer Conflict	Recent illness
Flashbacks	Hyperactive	Clingy/Can't separate
Lying	Being Bullied	Sad
Nightmares	Defecating on self	Angry
Withdrawn	Short attention span	Anxious
Stubborn	Bed wetting	School Refusal
Daydreaming	Eating problems	Homework Refusal
Disobedient	Distractible	Hearing voices
Stealing	Self mutilating/Cutting	Fire Setting
Sibling Confilict	Idenitity concerns	Hurting Animals
Low self-esteem	Hair pulling	Mood swings
Talking to self	Head banging	Depressed
Fearful	Sleep problems	Running away from home
Irritable/Moody	Sad	Will not play with peers

Homicidal or talks about wanting to kill others
Suicidal or talks about wanting to die
Excessive time spent on computer or video games
Obsessive or repetitive behaviors

Please elaborate on time frame, triggers, or precipitating factors to any of the above circled:_____
_____

Changes in Your Child's Family:

Check off any recent changes in your child's family:
__ Death of a loved one
__ Significant loss (babysitter, friend, etc.)
__ Conflict between child's parents
__ Remarriage
__ Divorce or Separation
__ Change in living situation
__ Substance Abuse of parent, guardian, or sibling
__ Family member recently diagnosed with a mental health diagnosis
__ Parent loss of job
__ Incarceration of family member or other legal trouble
__ Serious illness or hospitalization of a family member
__ New Baby
__ Sibling moving away/going to college
__ Adoption
__ Foster Care
__ Traumatic Event (such as: fire, life threatening event, death, car accident, physical injury, domestic violence, child abuse, community violence, etc.):
_____
_____

Other:_____
__ _____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, Anxiety, Bi-polar disorder, suicide attempts, alcoholism, drug addiction, ADHD, PTSD Schizophrenia, etc.):
_____
_____
_____

Child's History of Abuse and Trauma

Physical Abuse:

Being abused by others:
_____

Patient abusing others:

_____

Sexual Abuse:

Being abused by others:

_____

Patient abusing others:

_____

Exposure to Sexual Behavior or Material:

_____

Emotional Abuse:

Being abused by others:

_____

Patient abusing others:

_____

Domestic Violence:

History:

_____

_____

Did Child Witness DV:

_____

Outcome:

_____

Child's Interests

Child's Strengths:_____

Child's favorite game/activity:

_____

Child's closest friend and/or family member:

_____

Briefly describe your child:

_____
_____
_____
_____

Therapy Goals and Treatment

Does your child know that you are going to have him or her start therapy?

_____
_____

Briefly describe your goals for your child and family for therapy:

_____
_____
_____

What family involvement would you like to see in the therapy?

_____
_____

List any questions you have about therapy or services:

_____
_____
_____