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CHILD INTAKE FORM

Please fill out this form for your child (12 and under), answer the questions below, and bring it to your initial intake session. Please note: Information you provide here is protected as confidential information.

Child's name: (Last) (First) (Middle Initial) Today's Date:

Address: (Building Number and Street) (City) (State) (Zip)

Home phone: ( ) May we leave a message? Yes No

Cell/Other phone: ( ) May we leave a message? Yes No

E-mail\*: May we e-mail you? Yes No

\*Please Note: E-mail correspondence is not considered to be a confidential medium of communication.

Referred by (if any):

What is the relationship of person filling out this form to Client:

EMERGENCY CONTACT INFORMATION

1. Name: Relationship:

Home: ( ) Cell/Other: ( )

2. Name: Relationship:

Home: ( ) Cell/Other: ( )

I give CAV Family Therapy, Inc. to contact the above emergency contacts for emergency reasons. Initials

DEMOGRAPHICS

Child's Birth Date: Age: Gender:

Name and age of parents: Mother: Father:

Name and age of Stepparents (if applicable):

Occupation of parents:

Ethnic Background:

Languages:

Physical Disabilities: Wheelchair User Deaf/Hearing Difficulties Since Birth

Deaf/Hearing Difficulties Due to Age/Accident Problems W/Sight Other N/A

**GENERAL AND MENTAL HEALTH INFORMATION**

1. What is the reason you are seeking therapy for your child? (Please describe any precipitating event(s), current symptoms and impairments in life functioning, including when the problem started and how often they experience symptoms).

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2. Has your child previously received any type of mental health services (psychotherapy, psychiatric, services, school counselor, hospitalizations due to mental health, etc.)?

No  Yes, previous therapist/practitioner: \_\_\_\_\_

Please describe how long they were seen, diagnosis (if any) and the treatment method that was used (or, what they liked, or disliked, about their previous therapist).

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3. Has your child ever had suicidal thoughts or attempted suicide?  No  Yes

3.1 If you marked yes to the previous question, when was the last time your child had suicidal thoughts or attempted suicide?

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4. Has your child ever been hospitalized for their suicidal thoughts, aggressive behavior, homicidal thoughts, or access to lethal means?  No  Yes

4.1 If you marked yes to the previous question, please list the date(s), location(s) of hospitalization, and what caused the events to occur: \_\_\_\_\_

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**GENERAL AND MENTAL HEALTH INFORMATION (Continued)**

5. Has your child ever engaged in self harm behaviors or rituals?  No  Yes

5.1 If you marked yes to the previous question, please list the type of self-harm your child engages in, or have engaged in, when it began, and any additional comments:

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6. Has your child ever had any trauma related experiences?  No  Yes

6.1 If you marked yes to the previous question, please describe the trauma that you are comfortable sharing and/or discussing (nature of trauma, when it occurred, persons involved, and impact on ability to function).

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**FAMILY MENTAL HEALTH INFORMATION**

7. Are you aware of any family history regarding psychiatric/mental health?

(Please list any family member that you know has had a mental health diagnosis)

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8. Has anyone in your family ever committed suicide or attempted suicide?  No  Yes

8.1 If you marked yes to the previous question, please list who committed or attempted suicide that you feel comfortable discussing.

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**FAMILY MENTAL HEALTH INFORMATION (Continued)**

In the section below, please indicate if there is any family history of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, sibling, etc.).

	Please check	List family member
Alcohol abuse	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Substance abuse	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Anxiety	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Mania	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Eating Disorder	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Obesity	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Obsessive compulsive behavior	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Auditory/Visual hallucinations	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Suicide attempts	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Trauma	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____
Domestic violence	<input type="checkbox"/> Yes   <input type="checkbox"/> No	_____

**MEDICAL CONDITIONS AND HISTORY**

9. How would you rate your child's current physical health? (Please check one of the boxes below)

Poor  Unsatisfactory  Satisfactory  Good  Very Good

Please list any specific health problems your child is currently experiencing:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10. Has your child ever had a serious past health issue that is no longer a problem?  No  Yes

11. If known, when was the date of your child's last medical physical? \_\_\_\_\_

12. How would you rate your child's current sleeping habits? (Please check one of the boxes below)

Poor  Unsatisfactory  Satisfactory  Good  Very Good

Please list any specific sleep problems your child is currently experiencing:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. How many times per week does your child generally exercise?: \_\_\_\_\_

14. What types of exercise does your child participate in?: \_\_\_\_\_

\_\_\_\_\_

**MEDICAL CONDITIONS AND HISTORY (Continued)**

15. Please list any eating difficulties your child has been experiencing:

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16. Does your child have any of the following types of allergies (Please list in the space provided)

Drug(s)  Food  Contact  Animal  Seasonal  Other

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17. Has your child ever been diagnosed with any developmental delays?  No  Yes

17.1 If yes, please list the diagnosis: \_\_\_\_\_

**BEHAVIOR CHECKLIST.** Please check any of the following that concern you and/or your parent/caregiver(s):

<b>Behavior:</b>	Current	Past	<b>Behavior:</b>	Current	Past
Sadness, crying	<input type="checkbox"/>	<input type="checkbox"/>	Irritable	<input type="checkbox"/>	<input type="checkbox"/>
Loss of enjoyment of usual activities	<input type="checkbox"/>	<input type="checkbox"/>	Anger issues	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Disobedient	<input type="checkbox"/>	<input type="checkbox"/>
Past suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	Problems at home	<input type="checkbox"/>	<input type="checkbox"/>
Self-harm or injuring self	<input type="checkbox"/>	<input type="checkbox"/>	Prefer to be alone or social isolation	<input type="checkbox"/>	<input type="checkbox"/>
Low self-worth	<input type="checkbox"/>	<input type="checkbox"/>	Identity concerns	<input type="checkbox"/>	<input type="checkbox"/>
Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Spiritual concerns	<input type="checkbox"/>	<input type="checkbox"/>
Low motivation	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	Phobias or fears	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Trauma flashbacks	<input type="checkbox"/>	<input type="checkbox"/>
Grief	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>
Excessive worry or overly concerned about things	<input type="checkbox"/>	<input type="checkbox"/>	Weight or appetite changes	<input type="checkbox"/>	<input type="checkbox"/>
Feeling panicky, anxious, nervous	<input type="checkbox"/>	<input type="checkbox"/>	Drug use	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
Restlessness	<input type="checkbox"/>	<input type="checkbox"/>	Problems with authority or the law	<input type="checkbox"/>	<input type="checkbox"/>
Trouble finishing things or disorganized	<input type="checkbox"/>	<input type="checkbox"/>	Frequently acting without thinking	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration/easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Disruptive	<input type="checkbox"/>	<input type="checkbox"/>			

**MEDICATIONS AND SUBSTANCE USE**

18. Is your child currently taking, or have taken, any prescription psychiatric medication?

No  Yes

18.1 If you answered yes to the question above, please list as much information about their medication as you know (Medication, Dosage, Purpose, Doctor)

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**FAMILY HISTORY**

19. Are or were the child's parents married?  No  Yes

20. Are or were the child's parents divorced?  No  Yes

21. Was the child adopted? If so, at what age?  No  Yes Age: \_\_\_\_\_

22. Does the child have stepparents?  No  Yes

23. Has any of the child's parents or siblings died?  No  Yes

If so, indicate name, cause of death, and when they died:

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24. Are there any siblings? (please list names and ages): \_\_\_\_\_

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25. Please describe the quality of the child's relationship(s) with their family members, as best you can:

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**SOCIAL, EDUCATIONAL, & PERSONAL HISTORY**

26. What is the child's current living situation (Where do they live and with whom)?:

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27. Is the child spiritual or religious or been raised with specific religious beliefs?  No  Yes

27.1 If yes, please describe their faith or belief: \_\_\_\_\_

28. Do they have any significant friendships: \_\_\_\_\_

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29. What school is the child currently attending and what grade level are they in?

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

30. How are they doing in school? (Grades, Behavior, Citizenship): \_\_\_\_\_

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31. What do they enjoy about school? \_\_\_\_\_

32. What do they dislike about school? \_\_\_\_\_

33. Are there any additional significant life changes or stressful events that have happened recently that has impacted your ability to adequately function?

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**SOCIAL, EDUCATIONAL, & PERSONAL HISTORY (Continued)**

34. What do you consider to be some of your child's strengths?

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35. What do you consider to be some of your child's weaknesses?

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36. What would you like for your child to accomplish out of their time in therapy?

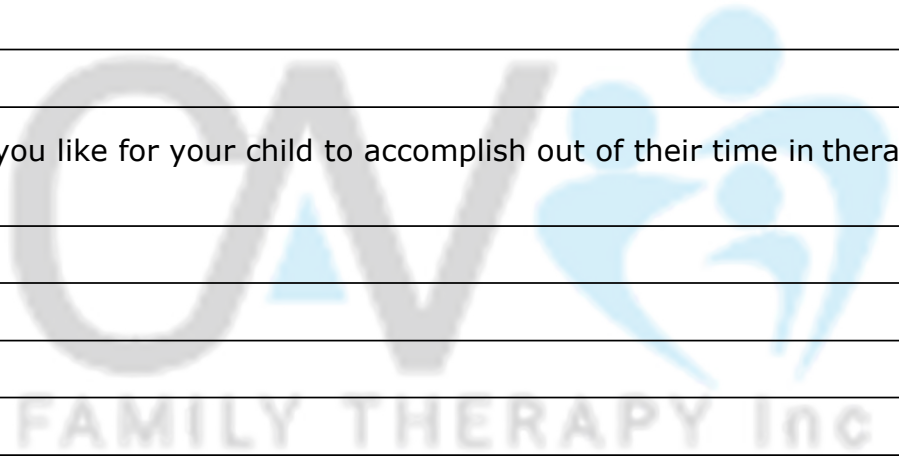
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Additional Notes:

Availability:

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Therapist Signature

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Date