Barstow Acres Children's Center, Inc.
590 Main St. Prince Frederick, MD 20678 • 410-414-9901 • Barstow.acrescc@yahoo.com

CHILD INTAKE FORM

Please provide the following information and answer the questions to the best of your ability. This is an important and necessary as part of the evaluation process. All information provided is protected as confidential information. Thank you!

GENERAL INFORMATION
Today's Date: _______________
Client Name: ___________________________ Client's Age: __________ DOB: _____________
Address: ____
____

Parent/Legal Guardian #1: ____________________________________
Home phone: ____________________________________ May I leave a message? **YES** **NO**
Cell phone: ____________________________________ May I leave a message? **YES** **NO**
Work phone: ____________________________________ May I leave a message? **YES** **NO**
Email: ____________________________________ May I leave a message? **YES** **NO**

Parent/Legal Guardian #2: ____________________________________
Home phone: ____________________________________ May I leave a message? **YES** **NO**
Cell phone: ____________________________________ May I leave a message? **YES** **NO**
Work phone: ____________________________________ May I leave a message? **YES** **NO**
Email: ____________________________________ May I leave a message? **YES** **NO**

REFERRAL SOURCE
Referral Name:____ Title: _____________________
Phone #: ____________________________
May I contact the agency/person to thank them for referring you? **YES** **NO** Please initial: ___________

PURPOSE OF EVALUATION AT THIS TIME
What is the main reason(s) you're seeking help for your child? _______________________________________
____
____
____
____

How long has you child been experiencing this issue(s)? ____

Please describe prior attempts to solve issue(s): ____
____
____
____

What are your hopes regarding your child's therapy? ____
____
____
____

PRIOR CONSULTATIONS (Please include contact names and dates with other professionals, therapists, treatment providers)____

____

____

____

OVERALL STRENTHS (Please describe your child's strengths)______________________________

____

____

____

OVERALL WEAKNESSES (Please describe your child's weaknesses)__________________________

____

____

____

YOUR CHILD'S FAMILY

	Biological Mother	**Biological Father**	**Step/Adoptive Mother**	**Step/Adoptive Father**
Current Age (If deceased, please provide date, age, and cause of death)				
Country of Origin				
Occupation				
Religious/Spiritual Affiliation (If applicable)				
Any history of the following Please circle all those who apply	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol/Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol/Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol/Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol/Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have				

Parents are (circle one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? ___________________

If married, please check current satisfaction level of marriage: ☐Happy ☐Content ☐Distant ☐Other

Child lives with (circle one): Both Parents Mother Father Other: ___________________________

Is there a legal documentation of custody? **YES** **NO** (If yes, please provide copy)
Who has legal custody? ____

Please describe the current visitation schedule (if any) and type of communication with the child's other parent:
____

Is other parent aware of counseling visits? **YES** **NO**

Siblings
Please list your child's brothers and sisters in the order of birth (include adopted or step siblings)

First name	**Biological, Adopted, or Step**	**Current Age**	**School Grade**	**Male/ Female**	**Lives with you? (Yes/No)**	**Any medical, social, or academic problems?** (please list for each)

How does your child interact with his/her siblings? Please describe relationship. ___________________________
____
____

Family Mental Health History
In the section below identify any members of your family **and** extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	YES/NO Please circle	**LIST FAMILY MEMBER(S)**
Anxiety (General)	**YES NO**	
Obsessive Compulsive Behavior	**YES NO**	
Depression	**YES NO**	
Suicide Attempts	**YES NO**	
Bipolar/Manic Depressive	**YES NO**	
Alcoholism	**YES NO**	
Substance Abuse	**YES NO**	
Domestic Violence	**YES NO**	
Eating Disorder	**YES NO**	
Obesity	**YES NO**	
Schizophrenia	**YES NO**	
Counseling or Psychotherapy	**YES NO**	
Psychiatric Hospitalizations	**YES NO**	

HEALTH/MENTAL INFORMATION

Does your child currently have any medical problems? ____

____

____

____

Has your child ever been treated for any of the following?

Head Injury	**YES**	**NO**	Meningitis	**YES**	**NO**
Loss of Consciousness	**YES**	**NO**	Seizures	**YES**	**NO**
Frequent Ear Infection	**YES**	**NO**	Asthma	**YES**	**NO**
Hearing Problems	**YES**	**NO**	Elevated Lead Levels	**YES**	**NO**
Vision Problems	**YES**	**NO**	Allergies	**YES**	**NO**
Headaches	**YES**	**NO**	Surgeries	**YES**	**NO**

Other: ____

Has your child previously seen a therapist or psychiatrist? **YES** **NO**

If yes, please provide the following information including dates, reason, frequency, and outcome: ___________

____

____

____

Has your child ever been hospitalized for medical or mental illness? **YES** **NO**

If yes, please provide information regarding when, where, and reason: ________________________________

____

____

____

Please list ALL your child's current prescription medication with dosage:

1. ______________________________________ Dosage: ________________________________
2. ______________________________________ Dosage: ________________________________
3. ______________________________________ Dosage: ________________________________
4. ______________________________________ Dosage: ________________________________

Do you suspect that your child drinks alcohol? **YES** **NO**

Do you suspect that your child uses recreational drugs? **YES** **NO**

Who is your child's primary care physician? ____________________________ Phone: ________________

Who is your child's psychiatrist (if applicable)? _________________________ Phone: ________________

When was your child's last complete physical exam (mo/year)? ____________________________

DEVELOPMENTAL HISTORY

Pregnancy and Birth

Were there any complications during pregnancy (high blood pressure, diabetes, hospitalizations) **YES** **NO**

If yes, please describe: ____

Medications used during pregnancy? **YES** **NO** If yes, please list: ________________________________

Smoking? **YES** **NO** How much? ____

Alcohol? **YES** **NO** How much? ____

Drugs? **YES** **NO** How much? ____

Length of pregnancy? _______ Weeks   Age of mother at birth: _______   Birth weight: ____________

Were their any complications during delivery? **YES** **NO** If yes, describe: _____________________________
____

Developmental Milestones and Early Development

At what age did your do the following? (Indicate approximate month or year of age for each)

Roll over ____________   Walk ____________   Throw ball ____________
Crawl ____________   Run ____________   Bladder Control ____________
Sits w/o support ____________   Ride Tricycle ____________   Bowel Control ____________

Sexual Development

Gender identity: __________________________
Are there any sexual development issues that we should be aware of? **YES** **NO**
If yes, please explain: ____

CHILD'S SCHOOL, HOME, SOCIAL, & PERSONAL FUNCTIONING

School/Academics

Child's current grade: ____________   Has he/she ever repeated a grade? **YES** **NO** Is yes, which?________
School Name: ____________________________   School District/County: ____________________________

What preschool experience did your child have? ____
Where any problems detected in your child's kindergarten screening? **YES** **NO**
If yes, please explain: ____

Is your child in a regular classroom? **YES** **NO**   Does you child have a 504 Plan? **YES** **NO**
Does your child have an IEP? **YES** **NO**   Has your child ever received tutoring? **YES** **NO**

What are your child's typical grades? ____
Has their been a recent change with your child's academic performance? **YES** **NO**
If yes, explain: ____

Has your child ever been suspended from school? **YES** **NO**
If yes, please provide the length and circumstances of the suspension: ________________________________
____

What are your child's strongest points academically? ____
____

What are your child's weakest points academically? ____
____

Are you satisfied with your child's educational program? **YES** **NO**
If no, explain: ____

Home/Family Life

What are 5 things that you enjoy most about your child? ____

____

____

____

What are some activities you engage in as a family? ____

____

Is there any religious customs that we should be aware of? **YES NO**

If yes, explain: ____

Does your child listen and obey instructions 75% of the time? **YES NO**

Does your child utilize electronics at home? **YES NO**

If yes, please estimate the about of time on electronics per week. ___________hrs/week

What electronics does your child use? Circle those that apply.

TV Cell phone Gaming System Computer Other: _________________

Describe your parenting style. ____

____

What are your discipline techniques? ____

____

What are <u>your</u> strengths as a parent? ____

____

What are <u>your</u> areas of needed growth? ____

____

Social and Community Engagement

What are your child's favorite activities or hobbies? ____

What extracurricular/community activities is he/she involved with? ____

____

How does your child get along with other children? ____

____

Sleeping Habits

Is it difficult for your child to fall asleep? **YES NO**

Is it hard for your child to stay asleep? **YES NO**

Does your child share a room? **YES NO**

Does he/she share a bed? **YES NO**

Typically, how many hours of sleep per night? _______ hrs

Nutrition/Eating Habits

Do you have concerns about your child's eating habits? **YES NO**

If yes, please explain: ____

Does your child enjoy eating? **YES NO**

What does your child enjoy eating or have difficulties with? ____
____

Symptoms/Problems
How much are each of the following areas currently a problem for your child?

	Not at all	A little	Somewhat	Considerably	Terribly
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol/Substance Abuse	1	2	3	4	5
Parent/Child Conflict	1	2	3	4	5
Sibling Conflict	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/Religious	1	2	3	4	5
Legal Problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? **YES** **NO** If yes, please describe: ____
____
____
____

Has your child experienced any recent loss (death of a family member, friend, pet, etc.)? **YES** **NO**
If yes, please provide additional information date of loss, relationship, etc. ______________________________
____
____

How does child handle self when angry?____
____

RISK ASSESSMENT
Has your child ever been the victim or witness of trauma such as abuse (sexual, physical, neglect) or domestic violence? **YES** **NO**
If yes, please describe (when, where, how long): ____
____
____
____

Has your child ever tried to hurt him/herself? **YES** **NO**
If yes, please describe (when, where, what did they use): ____

Are you aware of your child having any suicidal thoughts or ideations? **YES** **NO**
Are you aware of your child participating in cutting or other self-injury behaviors? **YES** **NO**

Has your child ever tried to hurt someone else? **YES** **NO** If yes, please describe (when, where, what did they use): ____________________

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child? ____________________

SIGNATURE:
I acknowledge that this information is as accurate as possible and agree to the statements listed.

____________________ ____________________
Signature Date

Relationship to client: ____________________

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SUMMARY OF FINDINGS- DIAGNOSTIC FORMULATION

Client Name: ____________________________ Client ID: _____________ DOB: _____________

A. Summary of Reason for Visit/Presenting Issues: ____

____

____

____

____

____

____

____

____

B. Clinical Observations: ____

____

____

____

C. Clinical Formulation (Psychodynamic): ____

____

____

____

____

D. DSM-V Diagnosis (ICD-10): ____

E. Preliminary Treatment Plan:

List 3 problems:

a. ______________________________

b. ______________________________

c. ______________________________

1. Long Term Goal:

2. Short Term Goal:

Signature:

Provider and Credentials: ___________________________________ Date: ____________________