



Barstow Acres Children's Center, Inc.
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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's Age: _____ DOB: _____
 Client Name: _____
 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 STRENGTHS (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

Alcohol? YES NO How much? _____
Drugs? YES NO How much? _____

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

Were there any complications during delivery? YES NO If yes, describe: _____

Developmental Milestones and Early Development

At what age did you 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? _____

Were 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 your 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 there 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 your strengths as a parent? _____

What are your 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

Does your child share a room? YES NO

Is it hard for your child to stay asleep? 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? _____

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? _____

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: _____