# Indy Therapy and Counseling - CHILD Client Intake Form

The purpose of this intake form is to save a great deal of valuable therapy interview time. Therefore by answering these routine questions as fully and accurately as you can, it will make it possible for us to get to work on the issues that concern you the most more quickly. All responses are strictly confidential and will not be released without your written permission. If you have any questions about this questionnaire, please feel free to call.

**CHILD Name** _____Date of Birth:_____

**PARENT Name** _____

Address_____

City_____State_____Zip _____

Primary Phone (_____)_____ ( home / mobile / work / other )

Secondary Phone (_____)_____ ( home / mobile / work / other )

Employer _____

Email:_____

Emergency Contact _____

Name Relationship Contact #

**Is parent responsible for billing? YES / NO**
**If not, please fill out Billable Party information.**

**BILLABLE PARTY Name** _____

Address_____ City_____ State____ Zip _____

Primary Phone (_____)_____

## Communication of Private Mental Health Information

There may be times when Indy Therapy and Counseling staff needs to contact you in regards to appointment times, account questions, or other reasons relating to your care.
May we contact you by listed email? **YES / NO** May we leave a voicemail? **YES / NO**

**How did you hear about us?**

_____

**Behavioral Excesses:**
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

**Behavioral Deficits:**
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

**Behavioral Assets:**
What does your child do that you like? What does he/she do that other people like?

**Others Concerns:**
Do you have any other concerns about your child or your family that you have not mentioned yet?

**Treatment Goals:**
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

## Family History:

The name of the child's biological parents:

Mother: _____ Father: _____

Who has legal guardianship of your child?
Who are other household members with your child?

| **Names** | **Ages** | **Relationship to child** |
|---|---|---|

Who are your child's significant others NOT living with your child?

| **Names** | **Ages** | **Relationship to child** |
|---|---|---|

Please describe any past counseling that either your child or any family member has had.

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? (YES / NO) If yes, please describe:

## Education History:

What school does your child attend?

Address:

Phone: _____ Teacher's Name: _____ Current Grade: _____

What does your child's teacher say about him/her?

Other schools attended (including pre-school):

Has your child ever repeated a grade? If so which one(s)?

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

| | | | |
|---|---|---|---|
| Fighting | Lack of friends | Drug/Alcohol | Detention |
| Suspension | Learning Disabilities | Poor attendance | Poor grades |
| Gang influence | Incomplete homework | Behavior problems | |

# Medical History:

What is the name of your child's primary care physician? _____

Address: _____ Phone: _____

Date of your child's last medical examination: _____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems?

| | | | |
|---|---|---|---|
| A serious accident | Hospitalization | Surgery | Asthma |
| A head injury | High fever | Convulsions/seizures | |
| Eye/ear problems | Meningitis | Hearing problems | |
| Allergies | Loss of consciousness | | Other |

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

## Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?

## Did we miss something?

Write anything else you would like your clinician to know before first appointment.

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