CW Counseling and Consulting, LLC

CHILD /ADOLESCENTS INTAKE FORM

Parents or Guardians: Please fill out one form per child

Child's Name: _____D.O.B.: _____ Age:_____
School:_____ Teacher:_____ Grade: _____
How does your child do in school academically? _____
How does your child do in school behaviorally?_____
Does your child have a learning or physical disability? __Y, __N, __Maybe.
Specify: _____
Does your child have a mental health diagnosis? __Y, __N, Specify_____
Does your family have any specific spiritual beliefs? _____
Child's residence: ___Biological parent's home ___ Relative's home
____Biological and step parent's home ___Foster Home ___ Adoptive Home
Parent's status: ___single, never married ___ married, when? ____ ___ separated, ____ ___
divorced , when ? ____ ___ live-in partner, how long ? ___ ___ widow , when ? ___
CUSTODIAL PARENT): NAME: _____
HOME ADDRESS:_____
_____ City:_____ State:_____Zip_____
E-MAIL: _____May we email you? ___Yes ___No
Phone: H: _____W: _____ Cell:_____
Best number to reach you __H __W __Cell __ May we leave a msg? ___Yes ___No
Occupation: _____Length of time at this position _____

NON-CUSTODIAL PARENT (if applicable): NAME: _____
HOME ADDRESS:_____
_____ City:_____ State:_____Zip_____
E-MAIL: _____May we email you? ___Yes ___No
Phone: H: _____W: _____ Cell:_____
Best number to reach you __H __W __Cell __ May we leave a msg? ___Yes ___No
Occupation: _____Length of time at this position _____
If separated or divorced, visitation schedule: _____
Any Involvement with CPS/DSS? ___ Y ___ N Describe:_____
People in household: (list names and ages)_____
_____
How many times has the child moved?____ Any current parental legal involvement? _____
Primary Care Physician: _____ Phone:_____
Last seen on: _____ Reason for last visit _____
Current medications: (Include dosage and frequency) _____
_____
Allergies: _____
List any birth complications (Ex: Premature, jaundice, C-section, etc.) _____
_____
During pregnancy, did mother use: __ Cigarettes, __ Alcohol, __ Drugs, __ Experience
Extreme Stress? Specify frequency, amounts, and duration: _____
_____
When did your child start to: Sit-up: ___ Crawl: ____ Walk: ___ Talk: ___ Toilet trained:
Reached developmental milestones: ____On time, ____Early, ____Late
Reached educational milestones: ____On time, ____Early, ____Late
List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)_____
_____

Does child use: __ Cigarettes, __ Alcohol, __ Drugs
Specify amount and frequency: _____
Do you feel your child has a problem with drugs or alcohol? ___ Yes ___No
If yes, what type of treatment has your child received for the above _____
Has the child been in counseling before: ___Y ___N, Age (s): _____
Name of prior therapist and reason for treatment:_____
May I contact them? ___Y ___N, Name/phone number:_____
List any history of mental illness or addiction in immediate or extended family (Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, ADHD, etc.): _____

_____

Has your child witnessed: domestic violence? __Y, __N,
Has your child ever experienced: verbal abuse? __Y, __N, physical abuse? __Y, __N, sexual abuse? __Y, __N, __Any thing Suspected? Specify_____

_____

Other stressors or traumas? _____
How does your child handle anger or change? _____
Has the child experienced any significant loss? If yes, explain: _____

_____

What do you view as your child's major strengths and positive traits? _____

_____

What are your child's hobbies? _____
What are 3-5 words that describe:
Mother: _____
Father: _____
Step parent: _____
Child: _____
Parental Relationship: _____
Check any symptoms your child displays:
___ Anger ___ Anxiety ___ Bed wetting ___ Acts out sexually ___ Substance abuse
___ Conduct problems ___ Controlling Day defecation ___ Running Away ___ Shy
___ Has unusual sexual knowledge ___ Plays out sexual themes ___ Peer problems
___ Day wetting ___ Defiance ___ Depression ___ Homicidal thoughts or actions
___ Drug or alcohol use ___ Hyperactivity ___ Masturbates excessively
___ Hyper vigilance ___ Isolation ___Lack of empathy ___Lack of motivation
___ Lethargy ___Low impulse control ___ Plays out violent themes ___ Sleeplessness
___ Low self-esteem ___ Lying ___ Nightmares ___Over/Under eating ___ Phobias
___ Stealing ___ Tantrums ___ Somatic Symptoms (Headaches/Stomachaches, etc).
___ Conduct Problems ____Fearful ____Hopeless ___Irritable ___Mania ___Paranoid
___ Poor Social Skills ____Obsessions ____Compulsions ___Worry ___Panic Attacks
___ Starts Fights ___Poor Concentration ___Disregards Rules ___ Self-Blame
___ Blames Others ___ Hallucinations ___Withdrawn ___ Anger towards authority
How is your child disciplined? Please list each method and frequency of use:

_____

_____

Please describe your child's sleeping patterns (frequency of sleep, any nightmares). _____

_____

_____

Describe any struggles you foresee related to counseling/ Who will bring your child for counseling

_____

_____

What 1-3 goals would you like your child to work on in therapy? _____

_____

_____

THIS FORM COMPLETED BY: _____Date_____

Life change checklist

Please rate events that have occurred in the past year or that you are still coping with

0-Has not occurred in the past year 1-Not stressful 2-Mildly stressful
3-Stressful, though manageable 4-Very stressful, need support
5-Extremely stressful, need immediate assistance

Personal

____ Death of a close friend or family member____ Change in eating habits
____ Personal injury, illness, or hospitalization____ Mental Health struggles
____ Pregnancy (or pregnancy of family member) ____ Loss of self confidence
____ Outstanding achievement (graduation, promotion, etc.)
____ Change in religious belief and practice ____ Suicidal thoughts
____ Change in recreational time/activity ____Homicidal thoughts
____ Trouble with the legal system ____ Problems with addiction
____ Other _____

Relationship

____ New significant relationship ____ Distress over sexual activity
____ Change in a significant relationship, including with family members and sibling
____ Disagreements over money ____ Increased emotional distance
____ Lack of communication ____Family member beginning or stopping work or school
____ Problems with another's use of alcohol, drugs, or gambling
____ Other _____

Household/community

____ Family member left home or in the process of leaving
____ Gain of a new member (birth, parents moving in, adoption, new placement)
____ Partner at home more or less than before____ Retirement of family member
____ Injury, illness or disability of family member ____ Change of residence
____ Change in health/attitude/behavior of a member of the household
____ Aggression/hostility/anger/yelling in the house ____ Difficulty with the family
____ Other _____

Work

____ New job, or new line of work ____ Quit a job
____ Fired from a job ____ Retired
____ Laid off ____ Less job security
____ Trouble with work associates ____ Demotion
____ Change in hours, conditions, travel, etc. ____ Promotion
____ Changes in financial status ____ Cant find work
____ Tension between partners or family members on the use of money
____ Other _____

School

____ Failing grades ____ Pressure to do well
____ Not understanding assignments ____ Peer pressure
____ Dropped out ____ Bulling

Addiction

____ Drug abuse (including prescribed) ____ working with a sponsor
____ Alcohol abuse ____ Treatment Center in past year.
____ Sober living house ____ Attend 12 step meetings
____ Relapse(s) ____ Substance abuse counseling
____ Other _____

ATTACHMENT SYMPTOM CHECKLIST FOR YOUNG CHILDREN

(if your child is older think back to ages 2-6 and respond about that time)

CHILD'S NAME: _____

DATE OF BIRTH: _____

	None	Moderate	Severe
1. Cries; miserable all the time, chronically fussy	_____	_____	_____
2. Resists comforting or nurturance	_____	_____	_____
3. Resists or dislikes being held	_____	_____	_____
4. Poor eye contact or avoids eye contact	_____	_____	_____
5. Flat, lifeless affect (too quiet)	_____	_____	_____
6. Likes playpen or crib more than being held	_____	_____	_____
7. Rarely cries (overly good baby)	_____	_____	_____
8. Angry or full of rage when crying	_____	_____	_____
9. Exceedingly demanding	_____	_____	_____
10. Looks sad or empty-eyed	_____	_____	_____
11. Delayed milestones (creeping, crawling, etc.)	_____	_____	_____
12. Stiffens or becomes rigid when held	_____	_____	_____
13. Likes to be in control	_____	_____	_____
14. Does not hold on when held (no reciprocal holding)	_____	_____	_____
15. When held chest to chest, faces away	_____	_____	_____
16. Doesn't like head touched (combed, washed)	_____	_____	_____
17. Generally unresponsive to parent	_____	_____	_____
18. Cries or rages when held beyond his wishes	_____	_____	_____
19. Overly independent play or makes no demands	_____	_____	_____
20. Reaches for others to hold him rather than parent	_____	_____	_____
21. Little or reduced verbal responsiveness	_____	_____	_____
22. Does not return smiles	_____	_____	_____
23. Shows very little imitative behavior	_____	_____	_____
24. Prefers Dad to Mom	_____	_____	_____
25. Get in and out of parents lap frequently	_____	_____	_____
26. Physically restless when sleeping	_____	_____	_____
27. Does not react to pain (high pain tolerance)	_____	_____	_____
28. Overly affectionate to strangers	_____	_____	_____
29. Feeding problems	_____	_____	_____
30. Speech development delayed	_____	_____	_____

Completed By: _____

Relationship to Child: _____ Date Completed: _____