CHILD INTAKE FORM

IDENTIFYING INFORMATION

Child's Birth Name (or name on ID): ____

Name child prefers to be called:____

Gender: _______________DOB: ____________________

Mother's Name: ____ DOB: __________________

Natural parent: ______ Relative: _____

Step Parent: ______ Adoptive Parent: ______

Father's Name: ____ DOB: __________________

Natural parent: ______ Relative: _____

Step Parent: ______ Adoptive Parent: ______

Address (Number and Street): ____

City: ___________________________ State: _____________________ Zip: __________________________

Phone: _____________________ Mom Cell/Work: ____

Dad Cell/Work:______________________________________Other:_________________________________

Primary Phone: ( ) __________________________ Other Phone ( ) _________________________

Is it okay to leave a messages? ________

Emergency Contact(s): __________________________________ Contact's phone ____________________

Permission to call in an emergency? _____Yes ____No

Referred by:_______________________

For what are you seeking help today? ____

Presenting Symptoms (Check all that apply for current; mark "Hx" for history of symptoms):

__ Temper outbursts	__ Impulsive	__ Shy	Other (explain):
__ Withdrawn	__ Anxiety/Nervous	__ Sensory issues	____________________
__ Sadness	__ Disobedient	__ Stealing	____________________
__ Fearful	__ Destructive	__ Lying	____________________
__ Clumsy	__ Mean to others	__ School trouble	____________________
__ Overactive	__ Obsessive	__ Bowel/bladder control	
__ Short attention	__ Bed wetting	__ Eating issues	
__ Distractible/Distracting	__ Self-harming	__ Sleeping issues	
__ Peer conflict	__ Irritability	__ Drug/Alcohol use	
__ Energy (high/low)	__ Concentration	__ Suicidal/Homicidal thoughts	

MEDICAL HISTORY

Has the child ever been hospitalized or treated for illness, physical ailments, emotional issues? _______
If yes, please explain where, when, and what for? ____

____

Has the child ever taken, or currently taking any medications? ___Yes ___No
If yes, please list medication name and frequency of dosage ____________________________________

____

Does the child have any allergies that you are aware of (i.e. latex, peanut, soy, etc.)? ________________

____

Name and contact of primary care Physician ____

____

LIVING ARRANGEMENTS

Number of moves in child's life _______ Ever placed, boarded, or lived away from family? ___Yes ___No

Describe: ____

Present home: Renting ______ Buying ______ House_____ Apartment ______

List all members of your household presently and indicate their relation to the patient: _____________

Are there firearms in the home? ___Yes ___No If yes, how do they get storeed? (hiding place, locked away, with/without ammo)

____

DEVELOPMENTAL HISTORY

Did mother have any illness or complications before delivery? ___Yes ___No If yes, please describe:

____

____

Did mother abuse alcohol/drugs during pregnancy? ___Yes ___No Full Term Pregnancy? ___Yes ___No
Complications at birth? (Describe if any)_________________________________

As far as you know, did your child meet developmental milestones at an appropriate age (i.e. rolling, sitting up, babbling, and eating)? ___Yes ___No *If no, please descrie:

____

____

EDUCATIONAL HISTORY

Name of School ____Grade:___________________

Does the child receive special services at school? ___Yes ___No If yes, which services (occupational, physical, speech, counseling, other)

TRAUMA HISTORY

Please list chronologically, to the best of your knowledge, any trauma history for the child (trauma may include natural disaster, accident, domestic violence, physical/emotional/sexual abuse, neglect, separation from others via death/divorce/cps involvement, etc; witness of scary event, or any other trauma as perceived by the child:

____

SOCIAL HISTORY

Please list any extracurricular activities: ____

Please describe the child's friendships: ____

__________________________________/___________________ ___________________
Name of person completing information/relationship to child Date

Children's
RELEASE OF INFORMATION

You may consent for personal information contained within your clinical record held by Denise Hie to be disclosed to/from the persons and/or agencies identified below for the following reasons:

- Planning and monitoring appropriate treatment.
- Case review and consultation with your physician and/or health care providers.
- Support and/or Involvement of family member(s) or significant other in treatment.

Your signature indicates that you authorize Denise Hie to release/receive/exchange information to the parties named below. You may revoke this consent at any time by providing written notice. Please refer to the Disclosure Statement for additional privacy information.

1. Name of the agency (if any) that referred you: ____
   Address: ____
   Phone: ____

2. Name of primary ***physician*** (if different from above): ______________________________________
   Address: ____
   Phone: ____

3. Any other parties ***(i.e. attorney, employer, community agency)*** that you authorize Denise Hie to give/receive/exchange information regarding your treatment:

   ____
   ____
   ____

4. ***Family member(s)/significant other*** who may participate in your therapy. Please indicate relationship to client.

   ____

   ____

Print Client's Name: _______________________________________ DOB: _________________________

Client's Signature: ____ Date: __________________________

Parent/Guardian Signature: ________________________________ Date: __________________________

Witnessed By: ____ Date: __________________________