Child Intake Form

FORM TO BE COMPLETED BY PARENT/GUARDIAN

PARENT/GUARDIAN INFORMATION

Name: _____ Date: _____

Home address: _____ City, State, Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email address: _____

For confidentiality, when and where do you prefer to be reached? _____

Marital Status: S ☐ M ☐ Sep. ☐ D ☐ W ☐ Date of Current Marriage/ Separation: _____ Number of Marriages: _____

Children's Names:

_____ Date of Birth: _____ ☐M ☐F

_____ Date of Birth: _____ ☐M ☐F

_____ Date of Birth: _____ ☐M ☐F

_____ Date of Birth: _____ ☐M ☐F

Occupation: _____

Name of other custodial parent: _____ Phone: _____

Do you have consent from the other custodial parent for treatment of said child? ☐ Yes ☐ No

If not, this will be required by the therapist before counseling may begin.

How much contact does the child have with his/ her biological mother/ father? _____

Please list specific days, times for your appointment availability:

__*Monday*	☐ morning ☐ afternoon ☐ evening	__*Tuesday*	☐ morning ☐ afternoon ☐ evening	__*Wednesday*	☐ morning ☐ afternoon ☐ evening	__*Thursday*	☐ morning ☐ afternoon ☐ evening	__*Friday*	☐ morning ☐ afternoon ☐ evening

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GENERAL INFORMATION ***(Complete all remaining information according to the child coming for treatment.)***

Name: _____ Date of Birth: _____ ☐M ☐F

The child is currently living with: _____

School: _____ Grade: _____

Extracurricular activities/ interests: _____

MEDICAL HISTORY

How would you rate your child's current physical health? ☐Excellent ☐Good ☐Fair ☐Poor

Is the child complaining of any physical problems (headaches, stomach aches, etc.)? _____

Previous hospitalizations for medical reasons:

Date: _____ Reason: _____

Date: _____ Reason: _____

Please list any medical conditions or disabilities: _____

MEDICATION(S) Over-the counter or prescription	DOSAGE

Please list any learning disabilities: _____

COUNSELING & PSYCHIATRIC HISTORY

Has the child had any previous counseling? ❑ Yes ❑ No If yes, for how long?_____

For what reason? _____ Name /location of counselor: _____

Has the child ever been diagnosed with or treated for any type of mental illness? ❑ Yes ❑ No

If yes, which type? _____

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness? ❑ Yes ❑ No

If yes, which type? _____

PSYCHIATRIC MEDICATION(S)	DOSAGE

REASONS FOR SEEKING HELP

What concerns about the child have led you to pursue counseling? _____

Where are these concerns causing the most problems? Check all that apply:

☐ Home ☐ Work ☐ School ☐ Other: _____

When did the present concerns begin to be a problem for the child? _____

What concerns about the child have been identified by others? _____

Please indicate which of the following areas are currently problems for the child. Check all that apply:

- ☐ Lack of motivation
- ☐ Excessive fears or anxieties
- ☐ Difficulty being away from specific family members
- ☐ Loss of interest in usual activities
- ☐ Hearing Voices
- ☐ Decreased/ increased appetite
- ☐ Hyperactivity
- ☐ Temper Tantrums
- ☐ Bullying/ picking fights
- ☐ Refusal to respond to authority
- ☐ Getting into trouble at school/ play
- ☐ Obsessions/ compulsion with specific activities
- ☐ Difficulty making or keeping friends
- ☐ Other: _____

How did you hear about Crossroads Counseling? What do you hope to gain from counseling? _____

Consent for Counseling of Minors (Age 17 & Under)

This is to certify that I give permission for the minor named above to participate in counseling offered by Crossroads Counseling Services.

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date _____

Emergency Contact Name _____ Relationship to child: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____