Welcome to Solace Counseling Associates. Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

CHILD INTAKE FORM (TO AGE 11)

For Parent/Guardian to Complete

Child's Name:_____ DOB:_____ Age: _____

School: _____Grade: _____

Race/Ethnic Origin: _____

Religious Preference: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

Problem Description (Please state the problems for which you want help for this child:)

_____

_____

_____

CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe:
   _____
2. Did your child have health problems at birth? Yes _____ No _____

If yes, describe: _____

3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

   Yes ___ No ___ Not sure_____

   If yes, describe: _____

4. Did your child have any unusual behaviors or problems prior to age 3? Yes ___ No ___

   Not sure_____ If yes, describe: _____

5. Has your child experienced emotional, physical, or sexual abuse?

   Yes ____ No ____ Not sure _____

If yes, describe: _____

Emotional/Behavioral/Chemical Issues *(Has your child recently or currently experienced the following?)*

CONCERN	YES	NO	CONCERN	YES	NO
Recent Suicidal thoughts			Difficulty sleeping		
Suicide plans			Depression,		
Suicide attempts			loneliness, or hopelessness		
Self-inflicted injury behaviors			Crying often		
A tendency to be shy or sensitive			Frightening dreams or thoughts		
A strong dislike of criticism			Often annoyed by little things		
A frequent loss of temper			Difficulty completing tasks		
Difficulty expressing feelings			Violent or destructive behavior		
Nervousness, anxiety, or worry			Difficulty remembering		
Difficulty relaxing			Difficulty concentrating		
Difficulty making decisions			Mental Confusion		
Difficulty making friends			Difficulty with eating		

Has your child ever been in court or picked up by the police? Yes _____ No _____
If yes, describe: _____

Do you think your child has tried cigarettes, sniffing, alcohol or drugs? Yes ____ No _____
If yes, describe: _____

Does your child have a cell phone Yes_____ No_____
How many hours of screen time *(computer, video games, TV)* does your child engage in daily? _____

PEER RELATIONS

1. Is your child socially: ___outgoing ____shy ____depends on the situation.

2. Has your child experienced any bullying? Yes_____, No_____

2. Is your child involved in any organized social activities (e.g. sports, scouts, music)? Yes_____, No _____

List activities_____

SCHOOL HISTORY

1. Has your child ever been held back a grade? Yes ____ No ____ If yes, what grade and what was the reason you choose to hold your child back:_____
2. What are the grades your child receives at school? _____
3. Do you feel your child is doing the best he/she can at school? Yes _____ No _____
4. Are there any behavior problems at school? Yes ____ No _____

   If yes, please explain: _____
5. How many schools has your child attended? _____

DISCIPLINE

Are there any concerns in regards to discipline? Yes ___No ___

If yes, please explain: _____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____

If yes, please explain your concern: _____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? ❒ Yes ❒ No

If Yes, where: _____

Approximate Dates of Counseling:_____

For what reason did your son or daughter go to counseling? _____

Does your son or daughter have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy? _____

What did you find **least helpful** in therapy? _____

Has your son or daughter used psychiatric services? Yes____ No____

If yes, who did they see? _____

If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes_____ No _____

Name of medication	Dates taken	Was it helpful? Y/N

HEALTH CONCERNS:

1. In general, this child's heath has been:

_____excellent (is rarely sick, when sick recovers very quickly)

_____good (is not often sick or injured, illnesses are fairly short-lived)

_____fair (frequently sick or injured, illnesses often linger or recur)

_____poor (chronically ill)

2. Name of physician: _____

3. Name of Clinic: _____

4. Medications:_____

MEDICAL HISTORY

Check the age(s) at which this child had any of the following health problems. If the child has never had the problem, check the box in the "Never" column. If the health problem is still continuing or is a current concern, check the box in the "Current Concern" column. More than one category may be checked.

CONCERN	NEVER	0-6 MONTHS	7-12 MONTHS	1-2 YEARS	2-4 YEARS	4-6 YEARS	SINCE 6 YEARS	CURRENT CONCERN
High fever (over 103°)								
Seizures (convulsions)								
Rashes or skin problems								
Meningitis								
Asthma								
Food allergies								
Other allergies								
Pneumonia								
Meningitis								
Anemia (low blood count)								
Heart problems								
Kidney or urinary problems								
Bowel problems								
Trouble with vision								
Trouble with hearing								
Lack of weight gain								
Poisoning or medication overdose								
Serious injury								
Hospitalization								
Surgery								

- Other important illnesses not listed: _____
- Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____
  If so, please describe. _____
- Inherited conditions (e.g. Huntington's Chorea, Sickle Cell Anemia): _____
- Other significant family illness: _____
- Does any parent/caregiver have difficulties with nervousness, anxiety, or depression? Yes ____ No_____
  if yes, please explain: _____
- Does any parent/caregiver have difficulties with anger, e.g. losing temper easily, verbally abusive, being violent when angry? Yes ____ No _____If yes, please explain: _____

FAMILY ILLNESSES/DISORDERS

	Mother's Family	Biological Mother	Biological Father	Father's Family
Anxiety disorders				
ADHD or ADD				
Mental retardation				
Seizure disorder				
Depression				
Schizophrenia				
Other psychiatric disorder				
Learning difficulties				
Behavioral problems				
Alcoholism or drug dependence				
Anxiety disorders				

CHILD'S STRENGTHS *(Please mark those strengths that you have observed in your child):*

	Often True	**Sometimes True**	**Seldom True**	**Cannot Say**
Outgoing				
Self-confident				
Seems happy				
Friendly				
Enjoys new experiences or activities				
Even disposition or steady moods				
Expresses feelings				
Affectionate				
Kind or sympathetic to others				
Shares				
Can compromise				
Follows rules easily				
Is forgiving				
Stands up for self when appropriate				
Tolerates criticism				
Recovers easily after disappointment				
Is appropriately cautious				
Creative				
Plays gently with smaller children or animals				
Good sense of humor				
Other…				

PARENT'S HISTORY

PARENT'S MARITAL STATUS *(this question refers to the biological parents relationship)*

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed ___Other

Length of marriage/relationship:_____

If divorced, how old was your child at time of divorce? _____

If divorced, How much time does your child spend with each parent? Mother_____%, Father _____%

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Biological Father's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Current Status _____Single, ____Married, ____Divorced, ____Separated, _____Widowed, _____Other

**Please answer if you are no longer with your child's bio-mother* OR *check here if you are still with bio-mother*_____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Biological Mother's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Current Status _____Single, ____Married, ____Divorced, ____Separated, _____Widowed, _____Other

**Please answer if you are no longer with your child's bio-father* OR *check here if you are still with bio-father*_____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____