Elizabeth
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Todays Date:_____

CHILD INTAKE

IDENTIFYING INFORMATION

Name: _____ D.O.B. ____/____/____ Sex _____

Place of Birth _____

Address _____

Parent/Guardian Primary Phone _____ (alternate) _____ (alternate) _____

Parent email address (*optional)*: _____

Child Ethnicity _____ Child Education level _____ School _____

FAMILY INFORMATION

Parental relationship status (*married, living together, separated, etc)*: _____

If separated - Name of other parent: _____ Involvement: _____

Who are the adults in the home? _____ birth foster step adoptive

_____ birth foster step adoptive

Other children/siblings:

Name	age	sex

Other adults in the home:

Name	relationship to child	time living in home

Emergency Contact Name/Relation: _____ Phone: _____

Referral Source (*who referred you)* _____

PRESENTING CONCERNS Please identify below any concerning symptoms or behavior in your child

Very unhappy	Slow response	Stubborn	Self mutilate	Stealing	Stomachaches
Irritable	Short attention span	Headaches	Head banging	Lying	Eating problems
Temper outbursts	Distractible	Disobedient	Rocking	School problems	Poor health
Withdrawn	Lacks initiative	Infantile	Nightmares	Truancy	Drug use
Daydreaming	Undependable	Mean to others	Shy	Sexual trouble	Alcohol use
Fearful	Peer conflict	Destructive	Strange behavior	Sleep problems	Suicide talk
Clumsy	Phobic	Legal trouble	Strange thoughts	Bed wetting	other:
Overactive	Impulsive	Running away	Fire setting	Soiled pants	other:

Comments: _____

Child Health History (birth, development, current health, health changes, medications, hospitalization, injuries, etc.)

Child School Assessment (academic performance, peer relations, etc.)

Name strengths/talents/skills/interests of your child

What are your top concerns at this time? How would your child's life be different if these were resolved?

Clinical Notes/Initial Session: