HOPE Counseling Center
Healthy **O**utcomes for **P**ersonal **E**nrichment
All Counselors are supervised by a licensed Marriage and Family Therapist

Child Intake Form

Client:_____

Date: _____ Therapist: _____

What are the issues that led you to decide to bring your child to therapy? _____
_____
_____
_____

Has your child received prior therapy related to any of the above concerns? ___Yes ___No

If yes, when: _____ Length of treatment: _____

What was the outcome (check one)?

___Very Successful ___Somewhat Successful ___Stayed the Same ___Somewhat worse ___Much Worse

What do you hope to accomplish in therapy for your child? _____
_____
_____

Please list siblings of the child (including step, foster, adopted):

Name	Sex	Age	Relationship to child	Describe him/her

Please rate how much support you and your family have overall:

1 ○	2 ○	3 ○	4 ○	5 ○
None	Very Little	Limited	Some	A lot

Are there any cultural, religious, spiritual, or ethnic factors for your family that you would like me to be aware of? ____Yes ____No
If yes, please describe: _____
_____
_____

What does your child enjoy doing in his or her free time, either on his/her own or with others? _____
_____
_____

What are your child's strengths and limitations? _____
_____
_____

What is your child's relationship like with other members of your family? _____
_____
_____

Where there any issues during the pregnancy or labor with your child? ____Yes ____No
If yes, please describe: _____
_____
_____

How would you describe your child as a baby? (fussy, happy, difficult etc.) _____
_____
_____
_____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems etc. in the last several years? ____Yes ____No
If yes, please describe: _____
_____
_____

Has there been any verbal, emotional, physical, or sexual abuse that has happened to your child that you are aware of? ____Yes ____No
If yes, was the assailant someone your child knew? ____Yes ____No
Where is this person now? _____

Has your child ever been involved with Child Protective Services? ____Yes ____No
If yes, please describe: _____
_____

Has your child ever had any legal issues? ____Yes _____No
If yes, please describe: _____
_____
_____

Is your child currently experiencing any suicidal thoughts? ____Yes ____No
Has your child had a suicidal attempt? ____Yes ____No
If yes, date of last attempt and treatment: _____
_____
_____

Has anyone in the family ever been hospitalized for psychiatric reasons? ____Yes ____No
If yes, please describe: _____
_____
_____

Does anyone in the family have any know mental health diagnoses? ____Yes ____No
If yes, please describe who and their diagnosis: _____
_____
_____

Does your child have a medical provider? ____Yes ____No
If yes, what is his or her name? _____

Does your child have any medical issues? ____Yes ____No
If yes, please describe: _____
_____
_____

Please list any medications your child is currently taking, or has taken during the past 6 months.
(Include prescribed and over the counter medications)

Medication	Dosage	Used for	Prescribing Doctor

Please share information about the substances that you know/believe that **your child** has used within the past year. Include street drugs and misuse of prescription medication.

Substance	How much and how often	When last used?	Age started using
Caffeine			
Tobacco			
Alcohol			
Marijuana/Pot			
Cocaine/Crack			
Opiates/Narcotics (i.e. pain killers)			
Barbiturates/Sedatives/Tranquilizers			
Amphetamines/Stimulants			
Hallucinogens/LSD/Psychedelics			
Other:			

Please share information about substance use by **other people** who are significant in your child's life.

Substance	Relationship to Client?	How much and how often?	When last used?
Caffeine			
Tobacco			
Alcohol			
Marijuana/Pot			
Cocaine/Crack			
Opiates/Narcotics (i.e. pain killers)			
Barbiturates/Sedatives/Tranquilizers			
Amphetamines/Stimulants			
Hallucinogens/LSD/Psychedelics			

Does your child do things that other people might think are impulsive, risky, or dangerous?
____Yes ____No
If yes, please describe: _____
_____
_____

Check any of the following symptoms or concerns that your child is currently or have recently experienced:

☐Stress	☐Aggression	☐Depression
☐Chronic Pain	☐Eating problems	☐Gender identity
☐Loneliness	☐Controlling	☐Trouble sleeping
☐Fatigue	☐Obsessive thoughts	☐Unwanted memories
☐Relational issues	☐Hearing voices	☐Pregnancy/Abortion
☐Low self-esteem	☐Racing thoughts	☐Anxiety
☐Compulsive behavior	☐Loss of control	☐Fears
☐Grief	☐Drug/Alcohol use	☐Panic
☐Sexual addiction	☐Impulsive behavior	☐Anger
☐Poor Concentration	☐Sexual concerns	☐Bad dreams

If you child is a student, does he or she enjoy school? ____Yes ____No
If no, please describe: _____
_____
_____

What are your child's peer relationships like? _____
_____
_____

Does your child want to attend therapy? ____Yes ____No

Any other information you think is important for me to know? _____
_____
_____
_____