# COUNSELING STRATEGIES, LLC

## CHILD INTAKE FORM

CHILD'S NAME ______________________________________________
FIRST MIDDLE LAST NICKNAME

M / F BIRTH DATE ____/____/_____ AGE_______ GRADE_________ SCHOOL__________________________

PLEASE RATE YOUR CHILD'S DEVELOPMENT IN THE FOLLOWING AREAS

SOCIAL ☐ BELOW AVERAGE ☐ AVERAGE ☐ ABOVE AVERAGE
EMOTIONAL ☐ BELOW AVERAGE ☐ AVERAGE ☐ ABOVE AVERAGE
INTELLECTUAL ☐ BELOW AVERAGE ☐ AVERAGE ☐ ABOVE AVERAGE
PHYSICAL ☐ BELOW AVERAGE ☐ AVERAGE ☐ ABOVE AVERAGE
LANGUAGE ☐ BELOW AVERAGE ☐ AVERAGE ☐ ABOVE AVERAGE
BEHAVIORAL ☐ BELOW AVERAGE ☐ AVERAGE ☐ ABOVE AVERAGE

BEHAVIOR CHECKLIST (PLEASE CHECK ALL THAT APPLY)

SLEEP ☐ AVERAGE ☐ EXCESSIVE ☐ WAKEFUL
☐ BEDWETTING ☐ NIGHTMARES ☐ SLEEPWALKS
APPETITE ☐ AVERAGE ☐ DECREASED ☐ INCREASED
☐ SOMATIC COMPLAINTS (HEADACHES, STOMACHACHES)
☐ DISPLAYS ACTS OF SELF-HARM
☐ AGGRESSIVE TOWARDS PEERS
☐ QUICK TO ANGER, IRRITABLE
☐ WITHDRAWN
☐ IMMATURE
☐ INSECURE/LACKS CONFIDENCE
☐ EXCESSIVE FEARS
☐ SEPARATION ANXIETY
SCHOOL ☐ ENGAGED ☐ UNMOTIVATED ☐ GIVES UP EASILY

☐ IMAGINATIVE/CREATIVE
☐ ATTENTION ISSUES
☐ HYPERACTIVE ☐ DAYDREAMER ☐ EASILY DISTRACTED
☐ DISRUPTIVE ☐ IMPULSIVE ☐ SHORT ATTENTION SPAN
☐ SENSITIVITY TO SOUNDS, TEXTURES, LIGHTS
☐ DIFFICULTY FOLLOWING RULES
☐ PERFECTIONIST
☐ LIES TO AVOID RESPONSIBILITY
☐ TAKES THINGS THAT ARE NOT HIS/HERS
☐ HAS MEANINGFUL FRIENDSHIPS
☐ HAS DIFFICULTY MAKING NEW FRIENDS
☐ SHOWS INTEREST IN LEARNING NEW THINGS
☐ PARTICIPATES IN EXTRACURRICULAR ACTIVITIES

BRIEFLY DESCRIBE YOUR CHILD'S CHALLENGES ______________________________________

BRIEFLY DESCRIBE YOUR CHILD'S STRENGHTS ______________________________________

BRIEFLY DESCRIBE YOUR GOALS FOR YOUR CHILD'S THERAPY ______________________________

HAS YOUR CHILD BEEN EVALUATED/TESTED FOR LEARNING DISABILITIES, DEVELOPMENTAL DELAYS, ACADEMICALLY GIFTED, ADD/ADHD, ETC? ☐NO ☐YES BY WHOM? ______________________ DATES______________
RESULTS__________________________________________________
IEP? ☐NO ☐YES RESULTS ___________________________________________

HAS YOUR CHILD EVER BEEN SEEN BY ANOTHER COUNSELOR? ☐NO ☐YES PSYCHIATRIST? ☐NO ☐YES PT/OT/SLP? ☐NO ☐YES
WHOM?______________________ DATES______________ OUTCOME______________
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WHOM?______________________ DATES______________ OUTCOME______________
DOES YOUR CHILD HAVE A MENTAL HEALTH DIAGNOSIS? ☐NO ☐YES__________________________
MEDICATION______________________ DOSAGE__________ PRESCRIBER______________
MEDICATION______________________ DOSAGE__________ PRESCRIBER______________
MEDICATION______________________ DOSAGE__________ PRESCRIBER______________
MEDICATION______________________ DOSAGE__________ PRESCRIBER______________

SIBLINGS (PLEASE LIST FROM OLDEST TO YOUNGEST)

NAME______________________________ M / F BIRTH DATE____/____/_____ AGE______ GRADE________
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# COUNSELING STRATEGIES, LLC
## CHILD INTAKE FORM

PARENT/GUARDIAN NAME______________________________ BIRTH DATE ___/___/___ AGE______

ADDRESS______________________________ CITY______________ STATE______ ZIP________

PHONE______________________________ E-MAIL______________________________
OKAY TO LEAVE MESSAGE? ☐ YES ☐ NO — OKAY TO LEAVE MESSAGE? ☐ YES ☐ NO *USED FOR SCHEDULING ONLY, NOT CONFIDENTIAL

OCCUPATION______________________________ EMPLOYER______________________________

RELATIONSHIP STATUS
- ☐ NEVER MARRIED
- ☐ MARRIED ___/___/___
- ☐ SEPARATED ___/___/___
- ☐ DIVORCED ___/___/___
- ☐ RE-MARRIED ___/___/___
- ☐ WIDOWED ___/___/___

OTHERS LIVING IN THE HOME
NAME______________________________ M / F
RELATIONSHIP______________________________ AGE______
NAME______________________________ M / F
RELATIONSHIP______________________________ AGE______

PARENT/GUARDIAN NAME______________________________ BIRTH DATE ___/___/___ AGE______

ADDRESS______________________________ CITY______________ STATE______ ZIP________

PHONE______________________________ E-MAIL______________________________
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- ☐ RE-MARRIED ___/___/___
- ☐ WIDOWED ___/___/___

OTHERS LIVING IN THE HOME
NAME______________________________ M / F
RELATIONSHIP______________________________ AGE______
NAME______________________________ M / F
RELATIONSHIP______________________________ AGE______

IF SEPARATED OR DIVORCED
VISITATION SCHEDULE______________________________
CUSTODY ARRANGEMENT______________________________

CURRENT FAMILY STRESSORS
- ☐ PARENTS SEPARATED OR DIVORCED
- ☐ SIGNIFICANT LOSS (FAMILY/FRIEND/PET)
- ☐ FAMILY FINANCIAL FROBLEMS
- ☐ FAMILY MOVED #TIMES _____
- ☐ PARENT CHANGED JOBS
- ☐ CHILD CHANGED SCHOOLS
- ☐ FAMILY ACCIDENT/ILLNESS
- ☐ OTHER ______________

FAMILY HISTORY (PLEASE PROVIDE DETAILS WHEN APPROPRIATE)
- ☐ SUBSTANCE USE ______________________________
- ☐ PHYSICAL ABUSE ______________________________
- ☐ SEXUAL ABUSE ______________________________
- ☐ FAMILY VIOLENCE ______________________________
- ☐ MENTAL ILLNESS ______________________________
- ☐ OTHER ______________________________

EMERGENCY CONTACT (OTHER THAN PERSON(S) LISTED ABOVE) NAME______________________________

RELATIONSHIP ______________________________ PHONE______________________________

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