Center for
BEHAVIORAL MEDICINE
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Intake Form

Client Information

Name_____ Date_____

Name preferred to be called/Nickname:_____

Address_____ City_____ State____ Zip_____

Child's Race: ❑African-American ❑Caucasian ❑Native American ❑Hispanic ❑Asian ❑Latino

❑Other (specify) _____

Age: _____ Birth date: _____ Grade level _____

Medication(s) Including dosage:_____

_____

Parent/Guardian Information

Parent/Guardian 1:

Name _____ age:_____

Occupation:_____ Highest level of education:_____

Phone: Home:_____ Cell:_____ Work:_____

EMAIL address:_____

Parent/Guardian 2:

Name _____ age:_____

Occupation:_____ Highest level of education:_____

Phone: Home:_____ cell:_____ work:_____

E-MAIL Address: _____

Preferred method to be contacted (check) ____Home phone, ____cell phone, ____e-mail

May I leave a message on phone? YES NO

Siblings:

Name_____ age:_____ full step half (circle)

Name_____ age:_____ full step half

Name_____ age_____ full step half

Name_____ age:_____ full step half

Pets:

____Dog, how many?____ name(s)_____

____Cat, how many?_____ name(s)_____

____Other, type?_____ name(s)_____

Family Dynamics

Please check all that apply:

____Parents are married and living together

____Parents are divorced and living together

____Parents are divorced and living apart in same state

____Parents are divorced and living apart in different states

____Mother is remarried

____Father is remarried

____Child lives with mother full time

____Child lives with mother part time

____Child lives with father full time

____Child lives with father part time

____Child lives with grandparent(s)

____Child lives in foster care

____Child lives with one parent and grandparents

____Child lives with aunt/uncle

____Other living arrangements: _____

Has the child ever been placed outside of the home? qYes qNo If yes, where? _____

In how many residences has the child lived since birth? _____

FAMILY MENTAL HEALTH HISTORY

Please check all that apply: Indicate relationship (ie, father, mother, sibling, grandparent)

___Depression:

___Bipolar disorder:

___Alcohol/drug addiction:

___Schizophrenia:

___Borderline Personality Disorder:

___Narcissistic Personality Disorder:

___Dissociative Identity Disorder:

___Enuresis/bedwetting:

___ADHD/ADD:

___Sexual abuse:

___Physical/mental abuse:

___Autism:

___Genetic disorder(s): Type?

___Epilepsy

___Phobia(s): type?

___Developmental delays:

___Hospital stay due to mental health issue

___Other:

DEVELOPMENTAL HISTORY

Was this child adopted? No Yes: From where?_____At what age?_____

Please circle all that happened during pregnancy with this child:

a. Regular prenatal care--attended scheduled doctor visits

b. took prenatal vitamins

c. Smoking: Packs per day _____

d. Alcohol: # of drinks per day _____

e. Marijuana use: Daily monthly few times during pregnancy

f. Other street drugs: list_____

g. Physical abuse of mother

h. Extreme stress of mother

i. Major illness of mother: name of illness_____

j. Complications during pregnancy? Describe-

k. Complications during delivery? Describe-

BIRTH HISTORY

1. Weight_____ Length_____ Delivery: Vaginal C-section

2. Premature birth YES NO If yes, how many weeks into pregnancy at birth?_____

3. Problems/illnesses at birth_____ admitted to NICU? YES NO

4. At what age did your child:

Sit_____ Say first word_____ Say two-word sentences_____

Crawl_____ Toilet Train_____ Walk_____ Learn to read_____

5. Would you say your child developed faster, slower, or about the same rate as other

children?_____

Please check any of the following physiological symptoms that apply to your child presently or in the recent past:

Headaches □ Past □ Present
Weakness □ Past □ Present
Change in Appetite □ Past □ Present
Dizziness □ Past □ Present
Tension □ Past □ Present
Tiredness □ Past □ Present
Stomach Trouble □ Past □ Present
Rapid Heart Rate □ Past □ Present
Pain □ Past □ Present
Other □ Past □ Present
Visual Trouble □ Past □ Present
Insomnia □ Past □ Present
Hearing Voices □ Past □ Present
Sleep Trouble □ Past □ Present
Intestinal Trouble □ Past □ Present
Seeing Things □ Past □ Present
Trouble Relaxing □ Past □ Present
Hearing Noises □ Past □ Present

How has your child's weight changed in the last 2---3 months? _____

SOCIAL HISTORY

1. Check all that describe your child socially:

_____Other children seek him/her out for play

_____He/She seeks others for play

_____He/She prefers to play alone

_____lots of children like him/her, FEW dislike him/her

_____lots of children like him/her, BUT lots of children dislike him/her

_____other children ignore my child most of the time

_____other children ignore my child some of the time

_____my child fights a lot with other children

_____my child play cooperatively with other children most of the time

_____my child has difficulty making friends

_____my child makes friends easily

2. How many friends does your child have at home?_____

3. How much time does your child spend playing with friends?_____

4. Does your child have a best friend? YES NO First Name?_____

5. How does your child get along with nonparent adults? (check all that apply)

____friendly ____cooperative ____disobedient ____disrespectful ___ obedient

____better behaved than with parents ____adults like my child

____other(describe)_____

6. How does your child get along with siblings?

____Protective ____aggressive ____won't share ____wants to be babied

____jealous ____ignores them ____plays well, limited arguing

____ plays well, but argues frequently ____always breaking up fights/arguments

7. Is your child sexually active? YES NO If yes, at what age?

8. Has your child ever been arrested, accused, or convicted of a crime? Please describe:

ACADEMIC HISTORY

1. Has your child attended day care? YES NO What age?

2. Age your child started Kindergarten?_____ Has your child repeated a grade? YES NO

Describe:

3. Does your child have a learning disability? YES NO Please indicate type and when diagnosed:

4. Does your child have an IEP? YES NO Please indicate type and when it was introduced:

5. What school subject(s) does your child enjoy and thrive in?

6. What school subject(s) does your child dislike and struggle with?

7. How would your child's teacher(s) describe him/her?

___Shy ___Overachiever ___Class clown ___Popular ___Trouble maker ___Other:_____

8. Please describe any issues or concerns you may have about your child's academics:

_____

_____

_____

_____

RELIGIOUS/SPIRITUAL HISTORY

1. Religion: ❑Protestant ❑Catholic ❑Buddhist ❑Hindu ❑Jewish ❑Muslim ❑Atheist ❑Agnostic

   ❑Other:_____

2. To what extent is faith, religion, or spirituality important in your family? Circle one:

Very important somewhat important not very important not at all important

3. My child has been baptized _____Yes _____No At what age_____?

4. Indicate your preference:

_____ I would like my child's counseling experience to include scripture and prayer.

_____ I do not want scripture or prayer used as part of the counseling experience.

MAJOR CONCERNS/ STRESSORS

Please describe your concerns regarding your child/reason for counseling:

_____

_____

_____

How does your child usually cope when under stress? Check all that apply

____tries to solve problem alone ____seeks information regarding problem

____asks parents or other adult for help ____asks friends for help

____gives up easily ____makes a joke about the problem ____prays or asks God for help

____refuses to talk about it- "holds it in" ____ignores or pretends there is no problem

____becomes anxious and/or tearful ____becomes angry and/or throws tantrums

____takes positive attitude toward problem ____get physically ill ____pretends to be ill

____becomes manipulative or deceitful ____withdraws, tries to be alone

____other: _____

All information is correct to the best of my knowledge.

_____ Date _____

Parent/Guardian Signature

_____ Date_____

Parent/Guardian Signature