



Child Intake Form

Identification Information:

Date: _____

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

Child's Primary Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

School: _____ Grade: _____ Teacher: _____

It is customary NewSong practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail, please provide an alternate mailing address here: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____

Guardian's Name (s): _____

Guardian's contact phone number: _____ Email: _____

With whom does the child presently reside? _____

FATHER

Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: (H) _____ (C) _____ (W) _____

Email: _____ Preferred method of contact: **Phone** or **Email**

Employer: _____ Occupation: _____

Gross Annual Income (before taxes) \$ _____

Marital Status (circle one): **Single** **Married** (yrs ____) **Divorced** **Widowed** **Separated**

Spouse / Significant Other: _____

Age when first married (if married): _____ Age at birth of child: _____

Has the child's father been previously married? **Yes** **No**

MOTHER

Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: (H) _____ (C) _____ (W) _____

Email: _____ Preferred method of contact: **Phone** or **Email**

Employer: _____ Occupation: _____

Gross Annual Income (before taxes) \$ _____

Marital Status (circle one): **Single** **Married** (yrs ____) **Divorced** **Widowed** **Separated**

Spouse / Significant Other: _____

Age when first married (if married): _____ Age at birth of child: _____

Has the child's mother been previously married? **Yes** **No**

Custody Arrangements: *(if applicable)*

Primary Residential Parent: _____

Visitation Schedule:

Client is with _____ on _____

Client is with _____ on _____

According to the Parenting Plan, who is authorized to make health care decisions? (circle one)

Father **Mother** **Joint** **Other (please specify):** _____

*** Please provide NewSong Counseling Center with a copy of the custody arrangement.**

Siblings / Other Household Members:

Name:	Relationship:	Age/Gender:	School/Grade:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What kind of relationship does the client have with his/her siblings? **GOOD** **FAIR** **POOR**

What kind of relationship does the mother have with this child? **GOOD** **FAIR** **POOR**

What kind of relationship does the father have with this child? **GOOD** **FAIR** **POOR**

How did the mother feel when this child was born? _____

How do the parents communicate love to the child? _____

What are the main methods of discipline used at home and how effective have they been?

Has the child ever experienced any type of abuse? (physical/sexual/verbal) If so, please

describe: _____

ADDITIONAL INFORMATION:

Has the child previously been in counseling? **YES** **NO**

If yes — Dates and Provider: _____

Child's response to treatment:

Why are you currently seeking counseling for the child? _____

Who referred you to NewSong Counseling Center? _____

MEDICAL/MENTAL HEALTH INFORMATION:

Medical conditions or illnesses: _____

Accidents or injuries: _____

Hospitalizations: _____

Child's Current Pediatrician: _____

When was your last medical check-up? _____

Is the child currently on any medications? **YES** **NO**
If yes, please list all of the medication(s) he/she is currently taking.

Has the child experienced any of the following? (please circle all that apply)

Surgery Asthma High fever Convulsions/seizures eye problems
Allergies Hearing Problems Loss of consciousness Other

Explain "other": _____

How would you rate the child's overall health? (please circle)

GOOD **10** **9** **8** **7** **6** **5** **4** **3** **2** **1** **POOR**

Please circle the disorders which any of the client's blood RELATIVES have had:

Alcoholism Drug Addiction Manic Depression Diabetes ADHD/ADD
Anemia Heart Disease Kidney Disease Stroke Veneral Disease
Asthma Low Blood Pressure High Blood Pressure Depression Psychiatric Treatment
Cancer Suicide attempt(s) Anxiety Fears Phobias
Hepatitis Epilepsy Obsession Compulsion with specific activities

Briefly describe significant family events which the child has experienced: (divorce, remarriage, death, domestic violence)

How does the child interact with family members? _____

DEVELOPMENTAL HISTORY:

Please describe the mother's pregnancy: _____

Were there any problems during the pregnancy of this child? **YES NO**

If yes, please describe: _____

During pregnancy, did the child's mother:

Smoke? **YES NO** Use alcohol? **YES NO**

Use street drugs? **YES NO** If yes, please list: _____

How was/is the child's physical health from 0-12 years? **GOOD FAIR POOR**

Explain anything unusual: _____

How was/is the child's physical development from 0-12 years? **GOOD FAIR POOR**

Explain anything unusual: _____

How was/is the child's emotional development from 0-12 years? **GOOD FAIR POOR**

Explain anything unusual: _____

Circle any of the following which did NOT occur in a typical developmental time period.

Smiled Sat without support Walked alone Spoke first word

Used two or three word sentences Completely weaned Started toilet training

Completely toilet trained Completely dressed him/herself

CHILD'S ACADEMIC HISTORY:

Does the child enjoy school? **YES** **NO**

Does the child have any learning challenges? If yes, please describe: _____

Has the child had any special testing or evaluation? If yes, please describe: _____

List any special services that the child is currently receiving: (tutoring, speech therapy, etc.)

What kind of grades does the child typically receive in school?

ABOVE AVERAGE

AVERAGE

BELOW AVERAGE

Has the child ever repeated a grade? If yes, specify which grade _____

Is the child involved in extra-curricular activities? (band, sports, etc.) If yes, please describe:

How many close friends does the child have? _____

How does the child relate to his/her classmates? **GOOD** **FAIR** **POOR** **UNSURE**

How does the child relate to his/her teachers? **GOOD** **FAIR** **POOR** **UNSURE**

Has the child experienced any of the following problems at school? (please circle all that apply)

Gang influence Incomplete Homework Behavior Problems Poor Attendance

Suspension Exposure to drugs/alcohol Detention Fighting

CHILD'S PRESENT PSYCHOLOGICAL STATUS:

Does the child experience any of the following personal habits? (please circle all that apply.)

Nail-biting Temper tantrums Nightmares Thumb-sucking
Bedwetting

Fears Phobias Running away Other

Explain "other": _____

How would you describe the child's personality? _____

Please list the child's hobbies or other interests. _____

Does the child have any pets? If yes, what kind(s)? _____

Is there anything currently bothering the child, causing worry or stress? If yes, please explain?

Has the child ever experienced any serious personal, emotional losses? Please describe.

How would you rate the child's temper? **SHORT** **MEDIUM** **LONG**

Has the child ever made statements of want to hurt self or someone else? **YES** **NO**

PRESENTING ISSUES:

Please describe any of the following concerns which the child may have:

Behavior _____

Relationships _____

Activities _____

Academics _____

Family Situation _____

Development _____

Habits _____

Gender Confusion _____

Other _____

Guardians's Signature: _____ **Date:** _____

Please tell me anything else that you would like for me to know about the child. (use back of page if needed)
