Child Intake Form

Child's First Name: ________________________________Middle Initial:______
Child's Last Name: ________________________________

Child's Gender: ___Male ______Female
Child's DOB: ______ ______ __________ Child's Age: ______
(Month) (Day) (Year)

Parent / Guardian Name: ______________________________________
Parent / Guardian Name: ______________________________________

Contact Information:

Address of Primary Care Parent: ______________________________________
City: ______________________ State: _____ Zip Code: ____________

Telephone: Preferred
(H) ____________________________ ☐
(W) ____________________________ ☐
(C) ____________________________ ☐

E-mail address: ____

Demographic Data:

Child's Ethnicity: ______________________________________
Child's School: ____
Child's Grade Level: __________________________

Name of Pediatrician: ____
Address:____
City: ___________________________ State: _____ Zip Code: _______

Church Attending: ______________________________________
How Long: ____________

Referral Source:
Check the appropriate box

Referred by: ☐ Doctor ☐ Pastor ☐ Former Client ☐ Website ☐ Insurance
☐ Other ____

Child's Family Background / History:

How would you describe your style of discipline?

____
____
____
____
____

Describe the child's personality (i.e. outgoing, shy, active, quiet and calm, likes to be alone, talkative, seldom talks, incline toward athletics or the arts, has lots of friends or has few or no friends)

____
____
____
____

What is the child's role in the family?

____
____
____
____

How does the child respond to stress?

____
____
____

Name and Age of Immediate Family Members:

Mother: ______________________________________ Age: ___
Father: ______________________________________ Age: ___

Step-Mother: ______________________________________
Step-Father: ______________________________________

(circle either brother or sister)
Bro. / Sis. ______________________________________ Age: ___
Bro. / Sis. ______________________________________ Age: ___
Bro. / Sis. ______________________________________ Age: ___
Bro. / Sis. ______________________________________ Age: ___
Bro. / Sis. ______________________________________ Age: ___
Bro. / Sis. ______________________________________ Age: ___

Other: ______________________________________ .Age: ___

Child's Developmental Background

(place a check by all that apply)

0-3 Months Old

__Smiles Responsively
__Turns head to sound
__Holds head up
__Grasps rattle
__Holds hands together
__Reaches for people/objects

3-9 Months Old

__Laughs and squeals
__Transfers toy from hand to hand
__Plays peek-a-boo
__Sits w/o support
__Feeds self crackers
__Imitates speech sounds

9-15 Months Old

__Bangs 2 blocks together
__Drinks from a cup
__Pulls self to stand
__Indicates wants
__Imitates sounds/words
__Begins to walk

16 Months to 2 Years Old

__Scribbles
__Uses spoon
__Removes clothing
__Runs well
__Talks in short sentences
__Plays alongside other children

3 to 4 Years Old

__Dresses w/o supervision
__Imitates
__Recognizes colors
__Comprehends tired, cold, hungry
__Can jump rope
__Print first name

5 to 6 Years Old

__Able to skip
__Plays a game following the rules
__Asks what words mean
__Draws a person
__Ties shoes
__Uses sentences well

7 to 9 Years Old

__Can throw a ball
__Can print sentences

__Recognizes value of coins
__Has friends
__Reads
__Begins to accept responsibility for

9 to 12 Years Old

__Writes in cursive
__Able to establish close peer friends
__Participates in discussions
__Argues
__Uses both hands independently

12 to 15 Years Old

__Peer group is very important
__Privacy is very important
__Tires easily
__Interest in opposite sex
__Recognizes consequences of behaviors
__Uses creative thought processes

Medical History:

Current physical complaints / problems: (indicate when complaint started)

____
____
____
____

Past serious medical problems: (give dates / any weight loss or gain, any head trauma or seizures)

____
____
____

Medication Usage:

Name of Medication(s)____
Start date: ____
Dosage: ____
Frequency of use: ____
Side effects ____
Beneficial: ___Yes ___No

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Start date: ____
Dosage: ____
Frequency of use: ____
Side effects ____
Beneficial: ___Yes ___No

Daily Activities at Home and School:

- Does the child follow a certain routine? If so please describe.

  ____
  ____
  ____
  ____
  ____

- What activities require assistance:

  ____
  ____
  ____
  ____

- Child's bedtime? ____________________ Naps: ______________________

(Note: Complete only for children 5 y.o. and older)

- Does the child complete his / her assignments?: __Yes __No
- Does the child have trouble with teachers? __Yes __No
- Does the child socialize with a group of friends? __Yes __No

Primary Problem / Complaint: (main reason child is coming for counseling)

____

____

____

Secondary Problems / Complaints:

____

____

____

Child's Symptoms:

Check all that apply

__Sleeping too much
__Sleeping too little
__Nightmares
__Eating too much or too little
__Weight loss or gain
__Sadness
__Depressed / down / hopeless
__Loss of interest in activities
__Low self-esteem
__Anxious / nervous / on edge
__Fearfulness
__Trouble relaxing
__Easily annoyed or irritable
__Headaches
__Hyper / can't sit still / restless
__Worrying about a lot of things
__Few or no social relationships

__Stressed
__Poor concentration
__Anger issues
__Behavior problems
__Harming self
__Harming others
__Destroying property
__Sexual abuse victim
__Physical abuse victim
__Emotional abuse victim
__Bullying others
__Victim of bullying
__Substance abuse
__Stomachaches
__Difficulty focusing on work
__Grief or loss
__Does not get along with others

Union Chapel Counseling Center

Informed Consent for Treatment

Client Agreement:

- I am aware that the practice of psychotherapy is not an exact science and that successful outcomes of counseling cannot be guaranteed and no promises about the results of treatment have been stated to me.
- The risks, benefits, side-effects, and alternative of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.
- I understand that I need to provide accurate information about myself and my concerns to my therapist so that I can receive effective treatment. I also agree to play an active role in my treatment.
- I understand that I may end treatment at any time. I agree to inform my therapist of my termination and the reasons why.
- I understand that all information share in the counseling sessions is confidential. However, I am aware that confidentiality can be broken in the case that I could harm myself, someone else or if a court of law requires the therapist to break confidentiality. I understand that my therapist may be supervised and the supervisor may have knowledge of my case except for my name.

I accept the above conditions with my Counselor(s) and agree to abide by them.

Confidentiality

CONFIDENTIALITY AND PRIVILEGED COMMUNICATION REMAIN RIGHTS OF ALL COUNSELORS. HOWEVER, SOME COURTS HAVE HELD THAT IF AN INDIVIDUAL INTENDS TO TAKE HARMFUL, DANGEROUS, OR CRIMINAL ACTION AGAINST ANOTHER HUMAN BEING, OR ONESELF, IT IS THE COUNSELOR'S DUTY TO WARN APPROPRIATE AUTHORITIES OF SUCH INTENTIONS. COUNSELORS ARE MANDATED BY INDIANA LAW TO REPORT ANY INCIDENCES OF "REASONABLE SUSPECTED CHILD ABUSE" (Physical or sexual). Union Chapel Counseling Center abides by this Indiana law. Thus, any "reasonably suspected child abuse (physical or sexual)" will be reported to the proper authorities. *Prior to informing any client who should be warned, the counselor(s) will make a concerted effort to share the intention of these laws with the client.*

I have read the above statements and understand the counselor's and supervisor's social and ethical responsibility to warn when harmful, dangerous, or criminal action is evident. I further understand the counselor's legal responsibility to notify the proper authorities in cases of "reasonably suspected child abuse" whether physical or sexual.

I acknowledge my receipt of Union Chapel Counseling Center's Notice of Privacy Practices effective date April, 14, 2003 on the date stated below.

______________________ Name of client (print)	______________ Date
______________________ Client's Signature	______________ If under 18, Parent or Guardian
______________________ Relationship to Client Signature	______________ Date
______________________ Counselor Signature	______________ Date