**Thrive Family Co.**

1152 2nd Avenue

Ladysmith, BC, V9G 1A1

Phone: (250) 924-4226

**Child Intake Form**

Today’s Date:

Child’s Name:

Sex:

Age:

DOB:

Natural Child? Yes / No

If adopted, at what age: Foster since:

Comments about custody and visitation (if applicable):

Siblings (please note each sibling’s name, age, and relationship to the child, such as full, step, half, or foster sibling):

**Personal History**

What is the reason you are bringing your child in for counseling? Is there something specific, such as a particular event?

If this is due to a specific event, when did this start or happen? How is the child’s life affected by this issue? Please be as detailed as you can.

Please check any symptom that is a concern. Note beside each item how long it has been a problem.

a.

 \_\_\_ Sleep problems

\_\_\_ Lack of interest in activities

 \_\_\_ Unassertive

 \_\_\_ Fatigue/low energy

 \_\_\_ Concentration problems

 \_\_\_ Appetite/weight changes

 \_\_\_ Withdrawal

\_\_\_ Morbid thoughts

\_\_\_ Suicidal thoughts or threats

 \_\_\_ Suicidal plans/attempts

 \_\_\_ Mood swings

 \_\_\_ Depression

 \_\_\_ Changed level of activity

 \_\_\_ Cries easily

b.

 \_\_\_ Forgetful/memory problems

 \_\_\_ Short attention span

 \_\_\_ Aggressive behavior

\_\_\_ Can’t sit still

 \_\_\_ Not interested in peers

 \_\_\_ Picked on/bullied by peers

 \_\_\_ Talks excessively/interrupts

\_\_\_ Easily distracted

 \_\_\_ Irritable

 \_\_\_ Impulsive

 \_\_\_ Difficulty following rules

 \_\_\_ Problems completing schoolwork

c.

 \_\_\_ Excessive worry/fearfulness

\_\_\_ Anxiety or panic attacks

 \_\_\_ Social fears/shyness

 \_\_\_ Separation problems

 \_\_\_ Bedwetting/soiling

 \_\_\_ Headaches/stomachaches

 \_\_\_ Odd beliefs/fantasizing

 \_\_\_ Nightmares

\_\_\_ Frequent tantrums

 \_\_\_ Resistive to change

 \_\_\_ School refusal

 \_\_\_ Perfectionism

 \_\_\_ Odd hand/motor movements

 \_\_\_ Hallucinations

d.

 \_\_\_ Lying

\_\_\_ Trouble with the law

 \_\_\_ Running away

 \_\_\_ Truancy, skipping school

 \_\_\_ Hurting others sexually

 \_\_\_ Alcohol/drug use

 \_\_\_ Argumentative/defiant

 \_\_\_ Swears

\_\_\_ Blames others for mistakes

 \_\_\_ Stealing

 \_\_\_ Being destructive

 \_\_\_ Fire setting

 \_\_\_ Hurting others/fighting

 \_\_\_ Act as if has no fear

 \_\_\_ Short tempered

\_\_\_ Easily annoyed/annoys others

 \_\_\_ Discipline problems

 \_\_\_ Angry and resentful

e.

 Below, please list any other symptoms not captured above:

How is your child disciplined? Please list each method and frequency of use:

What are your child’s strengths?

**School & Social Functioning**

Present School: Grade:

Has the child ever repeated any grade?

Is the child in special education services? If so, what kind?

Please describe academic or other problems your child has had in school:

**Pregnancy**

Mother used during pregnancy:

\_\_\_ Alcohol

\_\_\_ Drugs

\_\_\_ Cigarettes

Delivery:

 \_\_\_ Normal

 \_\_\_ Breech

 \_\_\_ Cesarean

 \_\_\_ Transactional

 \_\_\_ Full-term

 \_\_\_ Premature (if premature, number of weeks: \_\_\_\_ )

Birth weight:

Problems at birth (for example, infant given oxygen, blood transfusion, placed in an incubator, etc):

**Developmental History**

State the approximate age when your child did the following:

* Walked alone: \_\_\_\_
* Said first word: \_\_\_\_
* Used 2-word phrases: \_\_\_\_
* Understood and followed simple directions: \_\_\_\_
* Reasonably well toilet trained: \_\_\_\_
* Did child cry excessively? \_\_\_\_\_
* Rarely cried? \_\_\_\_

**Health History of Child**

In the first two years, did your child experience:

* Separation from mother: \_\_\_\_
* Out of home care: \_\_\_\_
* Disruption in bonding: \_\_\_\_
* Depression of mother: \_\_\_\_
* Abuse: \_\_\_\_
* Neglect: \_\_\_\_
* Chronic pain: \_\_\_\_
* Chronic illness: \_\_\_\_
* Parental stress: \_\_\_\_

Child’s doctor:

Date of last physical exam:

Does the child experience any vision, hearing, or dental problems? Please explain.

Does the child have a history of any serious illness, injury, handicaps, or hospitalizations? If so, please describe and give dates:

List any medications currently or previously used for emotional concerns with this child. Please note if they were helpful and provide dates:

Other medications for non-emotional issues currently used:

About how many hours a day does your child watch TV, play video games, or watch videos per day?

Please describe your child’s relationship with their phone, internet, and social media:

Has your child ever undergone previous psychological or psychiatric treatment? Please describe when, why, and the outcome:

Has your child undergone previous psychological testing? Please describe when, why, and the outcome:

**Experiences**

Has your child ever experienced any of the following? If so, please provide an age and brief description.

| **Experience** | **Age** | **Description (please note if this is still occurring now)** |
| --- | --- | --- |
| Physical Injuries (including concussions) |  |  |
| Physical Abuse |  |  |
| Emotional Abuse |  |  |
| Sexual Abuse/Assault |  |  |
| Significant Medical or Dental Experiences |  |  |
| Natural Disaster Involvement |  |  |
| Motor Vehicle Accidents |  |  |
| Chemical Use in the Home |  |  |
| Witnessing Domestic Violence |  |  |
| Other |  |  |

Is there anything else you’d like me to know?

**Signature**

Signature of person completing form:

Relationship to client:

Date: