**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: