Richards Counseling
Child Intake

Today's Date: ______________

Please provide the following information about your child:

Child's Full Name:____________________________________ Birth Date:____________

Nick Name:____

Parent Name: Mother:__________________________Father:___________________

Primary Phone Number: ______________________________________

Primary Address: ____

Family History:
The name of the child's biological parents:
Mother:____

Father:____

Who has legal guardianship of your child?_______________________________

Who does your child currently live with? ________________________________

Names	Ages	Relationship to child	Grade/Job

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

____

____

____

____

Behavioral Assets:
What does your child do that you like? What does he /she do that other people like?

Behavioral Concerns:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet.

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Who are your child's significant others NOT living with your child?

Names	Ages	Relationship to child	Grade/Job

Please describe any past counseling that either your child or any family member has had:

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? ____ If yes, Please

describe:____

____

Education History:

What school does your child attend?________________________________

Address:____

Phone:______________________Teacher's Name:______________________

Current Grade:_____________________

What does your child's teacher say about him/her?

____

____

Other schools attended (including Pre-school)

____

____

Has your child ever repeated a grade? If so which one(s)

____

Has your child ever received special education services?

____

Has your child experienced any of the following problems at School? (Circle)

* fighting * lack of friends * drug/alcohol * detention
* suspension * learning disabilities * poor attendance * poor grades
* gang influence * incomplete homework * behavior problems

Medical History:

How was the pregnancy and delivery of this child?
Normal ____ Complications _____ Unknown_____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications

during the pregnancy? ______.If so, please list which ones:

____

____

Did early developmental stages (walking alone, first words, toilet training) occur on time?
yes__ no__
If not, explain:
____

____

How is your child's current health? Excellent____ Good____ Poor____

What is the name of your child's medical doctor?

Address: ____

Phone:____

Date of your child's last medical examination:________________________

Has your child experienced any of the following medical problems? (Circle)

* A serious accident * Hospitalization * Surgery * Asthma
* A head injury * High fever * Convulsions/seizures
* Eye/ear problems * Meningitis * Hearing problems
* Allergies * Loss of consciousness * Other

Please list any current medical problems or physical handicaps:
____
____

Please list any medications your child takes on a regular basis and why:
____
____

Has your child ever been diagnosed with ADD or ADHD? Yes__ No__

If yes, please answer the following questions:

Which diagnosis? ADD____ ADHD____

Who gave the diagnosis?

Psychiatrist___ Medical doctor____ Counselor___

Is the person who gave the diagnosis aware of the family history of domestic violence?

Yes___ No___ Unsure____

Where was the diagnosis made? ____________________________________

Is your child currently receiving treatment for ADD/ADHD? Yes___ No___

Describe:____

Other History:

Has your child ever been directly abused? Yes___ No___

If yes, by whom? ____

What was the nature of the abuse (physical, sexual, or verbal? ______If so please describe:

____

____

____

Has your child been abused by anyone else? Yes__ No_

If yes, by whom? ____

Has your child ever witnessed domestic violence? If so, what has your child witnessed?

Physical__ Verbal___ Psychological____ Emotional___ (please check all that apply)

If so, have you talked with your child about the violence/abuse in your family?

yes__ no__ Please describe:____

____

____

Did your child try to stop the violence? yes__ no__

Has the violence disrupted your relationship with your child or your child's relationship with siblings? If yes, please describe:____

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else? _______

Has he/she ever purposely hurt himself or another? ________________________

If yes to either question please describe the situation:

____

____

____

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

____

____

____

Tell me about the way your child plays (what types of activities, plays alone, with others):

____

____

Regarding the following, what does your child do when she/he is:

afraid:____

angry:____

physically hurt:____

sad: ____

content:____

How does your child conflicts with other family members?

____

____

How does your child resolve conflict with peers (negotiates, withdraws, yells, hits)?____

If anything, what would you like to change about the way you parent?

____

____

____

Finally, what are some of the things that are currently stressful to your child and his/her family?

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