Meredith Counseling and Consulting, LLC
Child Intake Form

Child/Adolescent's Name: _____ Date: _____
Birthdate: _____ Referral Source: _____
Address: _____
_____
_____

Parent/Guardian's Name and Home Phone: _____ Okay to leave message? ☐
Parent/Guardian's Name and Cell Phone: _____ Okay to leave message? ☐ Text? ☐
Parent/Guardian's Work Phone: _____ Okay to leave message? ☐

Members of the Household:

Name	**Age**	**Relationship to Child/Adolescent**

List any children living outside the household and their ages: _____
_____

Family History

Is the child/adolescent adopted? ☐ Yes ☐ No If yes, at what age was he/she adopted? _____
Does he/she know of the adoption? _____

Are the child/adolescent's parents separated or divorced? ☐ Yes ☐ No If yes,

- When did the separation occur (month/year)? _____
- When was the divorce final (month/year)? _____
- Who has legal custody? _____
- Who has physical custody? _____
- What is the visitation arrangement? _____
- Does the noncustodial parent:
  - Know of this Evaluation? ☐ Yes ☐ No
  - Have limited/unpredictable contact? ☐ Yes ☐ No

- Have regular/frequent contact? ☐ Yes ☐ No
- Insure the child/adolescent? ☐ Yes ☐ No

If the child/adolescent does not live with the biological or adoptive parent(s) please state with whom he/she resides and the relationship with the foster parent/guardian: _____

_____

Please state why the child/adolescent is in foster care or with a guardian:_____

_____

Are the child/adolescents parents/guardians currently employed? _____If yes, please list position, title, name of employer, and length of time at employment: _____

_____

_____

If not working, length of time unemployed? _____

Does the family engage in a personal faith practice? _____ If yes, please describe: _____

_____

How important is faith/religion to your family? Check below.
Not important ☐ Somewhat important ☐ Very important ☐.

As a family, do you identify yourself with a particular cultural or ethnic group? ☐ Yes ☐ No
If yes, please note cultural/ethnic identification and the influence or role it plays in family life: _____

_____

Birth to Five Year Developmental History

Mother's Pregnancy: ☐ Normal ☐ Complicated (Explain _____

_____

Check any substances the biological mother used during her pregnancy and comment on any item checked: ☐ Tobacco ☐ Alcohol ☐ Drugs ☐ Medications
Comments: _____

Does your child/adolescent: Bed wet? ☐ Daytime wet? ☐ Soil and/or has bowel movements to underclothing? ☐ If yes, please comment:_____

_____

By or before the time your child entered kindergarten did you, your child's physician or any of your child's preschool teachers have concerns about any of the following areas of development? Please check

☐	Language development (use of words and sentences)	☐	Balance/Coordination	☐	Intelligence
☐	Speech Development (Pronunciation)	☐	Behavior Problems	☐	Hearing
☐	Fine Motor Development (pencil grip, coloring, cutting, etc)	☐	Vision		

Educational Background

Current School:_____
Has your child/adolescent repeated a grade? ☐ Yes ☐ No If yes, which grade(s)?_____

Has your child/adolescent been assessed for Special Education services? ☐ Yes ☐ No
If yes, when? _____
Is your child/adolescent receiving Special Education classes now? ☐ Yes ☐ No If yes, what type of Special Education? _____

Does the child/adolescent have an Individualized Education Program (IEP)? _____ If yes, please list individuals involved in formulating the IEP and their relationship to the child/adolescent: _____
_____
_____

Is the child/adolescent involved in any organized sports? _____ If yes, please note what activity and how many hours per week: _____

Medical and Mental Health Information

Describe the child/adolescent's physical health: Excellent ☐ Good ☐ Poor ☐

List any current medical problems and any medications prescribed to treat the child/adolescent's conditions:

Medical Condition	Medications taken (include dosages)

Please list any vitamins, herbal supplements or over the counter medications your child/adolescent is currently taking:
_____

Has the child/adolescent ever been in counseling? _____ Has he/she ever been hospitalized for a mental health concern? _____ If yes to either, please list:

Practitioner/Treatment Facility	Dates of Treatment	Issue Being Treated/Diagnosis

Has anyone in your child/adolescent's family ever been diagnosed with a mental illness? _____ If yes, please list relationship(s) and illness: _____
_____
_____

Has your child/adolescent ever talked about or attempted suicide? ☐ Yes ☐ No

If yes, when and what were the circumstances? _____

_____

Has anyone in the family ever attempted/completed suicide? _____ If yes, please list relationship to child/adolescent, date(s), method(s), and the child/adolescent's age at time of attempt:

_____

_____

Has your child/adolescent ever talked seriously about hurting or killing someone/something, or done so? ☐ Yes ☐ No If yes, please explain: _____

_____

To your knowledge has your child/adolescent ever been physically abused? ☐ Yes ☐ No
If yes, please explain. _____

_____

Has your child/adolescent ever been the victim of sexual abuse? ☐ Yes ☐ No
If yes, please explain: _____

_____

Please place an "X" next to any of the following that may be a concern for your child/adolescent.

☐ Worries	☐ Missing School Due to Illness	☐ Destroys Property	☐ Learning Problems
☐ Fears	☐ Frequent Physical Complaints	☐ Sets Fires	☐ Speech Problems
☐ Obsessive Thoughts	☐ Skipping Classes/School	☐ Cruelty to Animals	☐ Poor School Work
☐ Compulsive/Repetitive Behaviors	☐ Legal Problems	☐ Sexual Activity	☐ Mood Swings
☐ Odd Thoughts	☐ Runs Away from Home	☐ Reckless/Careless Behavior	☐ Sadness
☐ Odd Behaviors	☐ Tantrums, Angry Outbursts	☐ Disruptive Behavior	☐ Depression
☐ Disturbing Thoughts	☐ Bullies	☐ Messy	☐ Crying Spells
☐ Nightmares	☐ Argues	☐ Accident Prone	☐ Irritable
☐ Night Terrors	☐ Defiant/Oppositional	☐ Short Attention Span	☐ Withdrawn
☐ Insomnia	☐ Fights	☐ Distractible	☐ Boredom
☐ Sleepwalking	☐ Lies	☐ Hyperactive	☐ Significant Weight loss
☐ Will Not Sleep Alone	☐ Steals	☐ Impulsive	☐ Significant Weight Gain

Substance Use/Other Addictive Issues/Behaviors

Has your child/adolescent ever used alcohol and/or drugs? ☐ Yes ☐ No
If yes, and to your knowledge, please complete the table below.

Substance	Age When Use was Discovered or Suspected
Cigarettes	
Chewing Tobacco	
Alcohol	
Marijuana	
Cocaine/Crack/Meth	
Inhalants	
Stimulants	
Hallucinogens	
Heroin/Opiates	
Prescription Drugs (specify)	
Other (specify)	

Has your child/adolescent been treated for alcohol/drugs? ☐ Yes ☐ No
If yes, please list type, length, dates, and age at time he/she received services: _____
_____

Please indicate if any family member has ever used the substances below:

Substance	Family Member(s)	Amount of use	Frequency of use	Time period of use
Cigarettes				
Chewing Tobacco				
Alcohol				
Marijuana				
Cocaine/Crack/Meth				
Inhalants				
Stimulants				
Hallucinogens				
Heroin/Opiates				
Prescription Drugs (specify)				
Other (specify)				

Has any family member ever participated in drug and alcohol treatment? _____ If yes, please explain: _____

_____

Do any family members currently attend or has any family member ever attended Alcoholics or Narcotics Anonymous? _____
If yes, who? _____ Please list length of time sober and number of meetings the family member attends per week: _____

Does anyone in the family gamble? ___ If yes, who? _____ Has this family member ever lied to people important to them about how much they gambled? _____ Has this family member ever felt the need to bet more and more money? _____

Adolescent Work and Legal History

Did/does your adolescent work? ☐ Yes ☐ No If yes, please state name of employer and his/her position: _____

Is the adolescent involved in any civil or criminal legal proceedings? ☐ Yes ☐ No If yes, please explain: _____

Has our adolescent ever been charged/arrested for any offense in which drugs or alcohol have been involved? ☐ Yes ☐ No If yes, please explain: _____

_____

Is your adolescent presently on probation? ☐ Yes ☐ No If yes, please explain: _____

_____

Personal Concerns and Goals for Counseling

What are the primary issues for which you are seeking counseling/therapy for your child/adolescent?

1. _____
2. _____
3. _____

What do you hope to achieve through this experience? _____

_____

To the best of my knowledge, I attest that the information written on pages 1-6 is true and accurate.

_____ _____
Parent/Guardian Signature Date

_____ _____
Signature of Clinician Reviewing this Form Date

9/1/15