OAK CREEK RELATIONAL COUNSELING CENTER

CHILD INTAKE FORM
(PLEASE COMPLETE IN INK)

1. Child's Name: _____Sex:_____Age: _____DOB_____

2. Natural Child? Yes/No

   If adopted, at what age_____ Foster since _____

3. Parent's Names (include stepparents, foster parents)

_____

_____

4. Comments about custody and visitation (if applicable):

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5. Primary reason you are concerned about your child?

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SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

- Sleep problems
- Morbid thoughts
- Lack of interest in activities Suicidal thoughts or threats
- Unassertive
- Suicidal plans / attempts
- Fatigue/low energy
- Mood swings
- Concentration problems
- Depression
- Appetite/weight changes
- Changed level of activity
- Withdrawal
- Cries easily
- Forgetful/memory problems
- Talks excessively/ interrupts

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- Aggressive behavior
- Irritable
- Can't sit still
- Impulsive
- Not interested in peers
- Difficulty following rules
- Picked on / bullied by peers
- Problem completing schoolwork
- Fearfulness
- Nightmares
- Anxiety or panic attacks
- Frequent tantrums
- Social fears,
- Shyness
- Resistive to change
- Separation problems
- School refusal
- Bedwetting / soiling
- Perfectionism
- Headaches
- Stomachaches
- Odd hand / motor movements
- Odd beliefs / fantasizing
- Hallucinations
- Lying
- Stealing
- Trouble with the law
- Being destructive
- Running away
- Fire setting
- Truancy, skipping school.
- Hurting others / fighting
- Hurting others sexually
- Acts as if has no fear
- Alcohol / drug use
- Short tempered
- Argumentative / defiant
- Easily annoyed / annoys others.
- Swears
- Discipline problem
- Angry and resentful

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Brothers and Sisters

First Name	Last Name	Sex	Age	Relationship to Child (Full, Step, Half, Foster)

SCHOOL HISTORY

Present School	Grade	Teacher

Has Child ever repeated any grade?	
Is Child in special education services?	If yes, what kind

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

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CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

Substance use during Pregnancy	Alcohol	Drugs	Cigarettes
Delivery	Normal	Breech	Cesarean
Term	Full Term	Premature (# of Weeks____)	
Circle all that apply			

1. **Developmental History**
   State approximate age when child did the following:

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

2. **Health History of Child:** In the first two years, did your child experience:
   a. ___Separation from mother
   b. ___Out of home care
   c. ___Disruption in bonding
   d. ___Depression of mother
   e. ___Abuse
   f. ___Neglect
   g. ___Chronic pain
   h. ___Chronic Illness
   i. ___Parental Stress

3. Child's Doctor: _____
   - Date of last physical exam: _____
   - Vision problems? Yes _____No_____
   - Hearing problems? Yes _____No_____
   - Dental problems? Yes _____ No ____
   - Any head injuries or loss of consciousness? Yes _____No_____

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- Child's history of serious illness, injury, handicaps, or hospitalization? No _____Yes –describe and give dates:

_____

- Is your child currently taking any medications?
  No _____ Yes _____

  Name Medications

- List any medicines previously used for emotional problems: were they helpful?

  _____

- Allergies to drugs or medicines? No _____ Yes____
  (list) _____

- Allergies to any foods? No _____ Yes ____(list)
  _____

- Are there any foods that you limit or do not give this child? No ___
  Yes ___(list)
  _____
  _____

- Allergies to environmental conditions? No _____ Yes ____(list)
  _____
- Does anyone in the household smoke? No _____ Yes _____
- About how many hours does this child watch TV, videos, etc per day _____
- Are you afraid someone you know may injure/harm this child? No
  ____ Yes _____
- Does this child have a Health Care Directive? No _____ Yes ____
- If yes, please list where (clinic) it is on file
  _____

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- Any previous psychological or psychiatric treatment?
  No _____ Yes _____Whom/where _____
  when_____

- Any previous testing (school/psychological)? No _____ Yes
  _____Whom/where _____when_____

- Do you think your child's use of chemicals is a problem?
  No _____ Yes _____

  Type: Alcohol _____ Marijuana _____ Other drugs _____

  Comments:
  _____

  Family History: Chemical use (now & past): No __ Yes _____
  Which parent _____Type: Alcohol _____ Marijuana _____
  Other drugs_____

4. Has child witnessed domestic violence? _Y, _N, Specify:

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

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? __Y, __N, __Suspected. Specify:

2. Has your child been physically abused? __Y, __N, __Suspected. Specify:

3. Has your child been sexually abused? __Y, __N, __Suspected. Specify:

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4. Other stressors or traumas?

5. What are your child's strengths?

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