OAK CREEK RELATIONAL COUNSELING CENTER

CHILD CLIENT INTAKE FORM (AGE 2-11)

(Please complete in Ink)

CHILD

Child's

1. Name _____Sex _____Age ____DOB_____
   Address _____phone: _____

2. Natural Child Yes/No
   If adopted, at what age_____ Foster since _____

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

_____

_____

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

_____

_____

5. Primary reason you are concerned about your child?

_____

_____

_____

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

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- Depression
- Appetite/weight changes
- Changed level of activity
- Withdrawal
- Cries easily
- Forgetful/memory problems
- Talks excessively / interrupts
- Short attention span
- Easily distracted
- 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

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- 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
- Blames others for mistakes
- Angry and resentful

Brothers and Sisters

First Name Last Name. Sex. Age Relationship to child (full, step, half, foster)

1_____

2_____

3_____

4_____

5_____

SCHOOL HISTORY

1. Present School: _____Grade: ____
Teacher:_____

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2. Has child ever repeated any grade?
_____

3. Is child in special education services? No ____ Yes, what kind?
_____

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

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. Medical History :
   a. 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)_____
   _____

2. 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 child cry excessively? _____ Rarely cried _____

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3. 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

4. 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_____
- 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?

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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
  _____

- 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_____

5. List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

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_____

_____

6. Has child witnessed domestic violence? __Y, __N, Specify:

_____

_____

7. 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:

_____

4. Other stressors or traumas?

_____

_____

5. What are your child's strengths?

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