FAMILY COUNSELING CENTER

902 DeVille Lane
Ruston, LA 71270

CHILD INTAKE FORM

DATE: _____ Person completing form: _____

Who may we thank for referring you to FCC? _____

This form should be completed by child's parent/guardian before the first session. The information requested is confidential and will not be released without your authorization. This form is intended to provide information about child's growth and development that will be useful to the person who will work with him/her. Please answer all questions as accurately and fully as possible. See the therapist if you have any questions.

IDENTIFYING INFORMATION

Child's Name:_____ Age:_____ Date of Birth:_____

Name of Primary Guardian/s: _____

Relationship to child: _____Date of Birth:_____

Cell Ph: _____ Home Ph: _____ Email: _____

Address: _____ ZIP _____

School level completed: High School / Some College / Bachelor's / Master's / Doctorate

OTHER PARENT/CAREGIVER/GUARDIAN:_____

Relationship to child: _____Date of Birth:_____

Cell Ph: _____ Home Ph: _____ Email: _____

Address: _____ ZIP _____

School level completed: High School / Some College / Bachelor's / Master's / Doctorate

List all siblings/individuals who live in home (other than parents/caregivers):

NAME	RELATIONSHIP TO CHILD	AGE	NAME CHILD CALLS HIM/HER

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List grandparents/other contact person and name they are called by child:

HEALTH HISTORY

Name of Pediatrician: _____ Ph. #_____

Date of last medical exam: _____ Reason for visit: _____

Does child have any life threatening allergies (i.e. peanuts…) _____Yes _____ No

If yes, describe: _____

List all current medications child is taking:

NAME OF MEDICATION	SYMPTOM BEING TREATED

✓any medical/mental health diagnosis/symptom child has received/experienced:

___ ADHD	___ Headaches/Migraines	___ Seizures
___ Allergies	___ Hearing loss	___ Speech delay/problems
___ Anxiety Disorder	___ Head injury/loss of consciousness	___ Stomach aches
___ Asperger's Syndrome	___ Learning Disability	___ Surgery/hospitalizations
___ Autism	___ Nightmares	___ Tantrums
___ Bed Wetting	___ ODD/Conduct Disorder	___ Tubes in ears
___ Chronic ear infections	___ Insomnia	___ Vision problems
___ Depression	___ PTSD	Other:_____
___ Developmental Delay	___ RAD - Reactive Attachment Disorder	Other:_____

Complications with pregnancy? Explain: _____

Complications with birth? Explain: _____

Did child's mother smoke/use alcohol/drugs/medications during pregnancy? __yes __no

If yes, describe: _____

List any childhood diseases or serious injuries in child's history:_____

Other important medical information: _____

Has child ever received professional counseling? If so, when, by whom, for how long?

Has child's family (all or individually) received professional counseling? If so, when, by whom, for how long? _____

SCHOOL HISTORY

Name of school: _____ Grade: _____ Teacher: _____

Repeat grade? ____ Yes ____ No If yes, which grade? _____ Why? _____

Child's overall school performance (circle one): A / B / C / D / F

Does child have a behavior problem at school? Explain:_____

Has child experienced any of the following problems at school?

___ Fighting
___ Lack of friends
___ Drug/alcohol abuse
___ Detention/suspension
___ Learning disabilities
___ Poor attendance
___ Incomplete Homework
___ Bullying others
___ Bullied by others
___ Poor grades
___ Behavior Problems
Other: _____

SOCIAL HISTORY

List child's hobbies/interests: _____

List clubs/sports/organizations child in which child is involved:_____

Check any of the following that would accurately describe child:

___ Easily upset
___ Selfish
___ Hot tempered
___ Upset my criticism
___ Fearful
___ Low self-esteem
___ Eats too little/too much
___ Outgoing/friendly
___ Good humored
___ Self-confident
___ Transitions well
___ Hyperactivity
___ Aggressive/hostile
___ Imaginative/creative
___ Difficulty completing tasks
Other:_____
___ Impulsive
___ Easily distracted
___ Inflexible
___ Shy/withdrawn
___ Inflexible
___ Accident prone
___ Difficulty getting along with others
Other: _____

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GENERAL INFORMATION

Has child moved? ___ Yes ___ No / If yes, give brief history: _____

_____

_____

Child's relationship with brothers/sisters? ___ excellent ___ ok ___ poor

List any significant life events/losses child has experienced (ex: parental divorce, moves, separation from caregiver, deaths, accidents, natural disaster). Note age of child at time of the event:

EVENT / LOSS **AGE OF CHILD**

_____

_____

_____

How did child react to the above? _____

_____

Does child have a behavior problem at home? _____

_____

How would you describe parenting/discipline in the home? _____

_____

Generally, how does the child respond to discipline? _____

_____

What is child/family's religious affiliation if any? _____

Would you like to integrate religious issues with child's counseling sessions? _____ Yes _____No

Has child ever experience physical, sexual, or verbal abuse? _____ Yes _____ No

☛If yes, please complete FORM A

Has child ever been a victim of or witnessed domestic violence, crime, accident, or trauma?

Has child ever made statements of wanting to hurt self or seriously hurt someone else?

Explain: _____

Has child ever purposely hurt self or another? Explain: _____

Is there any other information you would like us to know about child?

Describe difficulties child is having now: _____

What is the main reason child is here today? _____

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FORM A: Client Information Form - Abuse

Parental Information:

Legal Custody: □ Mom □ Dad □ Shared □ Other _____
Name Relationship

Biological Mom: _____ city/state _____
Relationship to child? □ Excellent □ Fair □ Poor Regular contact? □ Yes □ No

Biological Dad: _____city/state _____
Relationship to child? □ Excellent □ Fair □ Poor Regular contact? □ Yes □ No

Lives With?

□ biological mom & dad _____
Names

□ biological mom □ biological dad □ other(s) _____
Name ***Relationship***

Type of Incident: □ sexual abuse □physical abuse □domestic violence □ neglect □ pornography

Age at time of incident _____ Perpetrator(s) _____
Name(s) Age(s)

Relationship to client: _____

Arrested or charged? □ Yes □ No □ Investigation pending? □ trial pending?

Forensic Interview Done? □ Yes □ No Where? _____

First Disclosed to: _____ Relationship to victim:_____

Reported? □ Yes □ No * Who to? □ Police Dept. □ Sheriff's Office □ DCFS (CPS)

Name of Agency Reported to: _____ Spoke to: _____

**If incident to minor child or adult 65 or older is unreported, therapist must either make a report or ensure that disclosing party makes a report to either law enforcement or Child Protective Services (DCFS (CPS)*

Effects of Incident: □ Behavioral Changes _____

□ bed-wetting □ nightmares / sleep disturbance □ Sexualized behavior □ fears/ phobias

□ anger/tantrums □ Depressed □ anxiety/ panic attacks □ invasive thoughts □ avoidance

□ non-compliant □ clingy □ other: _____

Former Counseling: When? _____ Where? _____
Who? _____ What for? _____How Long? _____