



### Child Intake Form

Client: \_\_\_\_\_

Date: \_\_\_\_\_

Therapist: \_\_\_\_\_

What are the issues that led you to decide to bring your child to therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child received prior therapy related to any of the above concerns? \_\_\_Yes \_\_\_No

If yes, when: \_\_\_\_\_

Length of treatment: \_\_\_\_\_

What was the outcome (check one)?

\_\_\_Very Successful \_\_\_Somewhat Successful \_\_\_Stayed the Same \_\_\_Somewhat worse \_\_\_Much Worse

What do you hope to accomplish in therapy for your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list siblings of the child (including step, foster, adopted):

| Name | Sex | Age | Relationship to child | Describe him/her |
|------|-----|-----|-----------------------|------------------|
|      |     |     |                       |                  |
|      |     |     |                       |                  |
|      |     |     |                       |                  |
|      |     |     |                       |                  |
|      |     |     |                       |                  |

Please rate how much support you and your family have overall:

1                      2                      3                      4                      5  
None                  Very Little                  Limited                  Some                  A lot



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**Healthy Outcomes for Personal Enrichment**

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Are there any cultural, religious, spiritual, or ethnic factors for your family that you would like me to be aware of? \_\_\_\_ Yes \_\_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What does your child enjoy doing in his or her free time, either on his/her own or with others? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What are your child's strengths and limitations? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is your child's relationship like with other members of your family? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Where there any issues during the pregnancy or labor with your child? \_\_\_\_ Yes \_\_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you describe your child as a baby? (fussy, happy, difficult etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems etc. in the last several years? \_\_\_\_ Yes \_\_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has there been any verbal, emotional, physical, or sexual abuse that has happened to your child that you are aware of? \_\_\_\_ Yes \_\_\_\_ No

If yes, was the assailant someone your child knew? \_\_\_\_ Yes \_\_\_\_ No

Where is this person now? \_\_\_\_\_

Has your child ever been involved with Child Protective Services? \_\_\_\_ Yes \_\_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_



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Has your child ever had any legal issues? \_\_\_\_ Yes \_\_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Is your child currently experiencing any suicidal thoughts? \_\_\_\_ Yes \_\_\_\_ No

Has your child had a suicidal attempt? \_\_\_\_ Yes \_\_\_\_ No

If yes, date of last attempt and treatment: \_\_\_\_\_  
\_\_\_\_\_

Has anyone in the family ever been hospitalized for psychiatric reasons? \_\_\_\_ Yes \_\_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Does anyone in the family have any know mental health diagnoses? \_\_\_\_ Yes \_\_\_\_ No

If yes, please describe who and their diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Does your child have a medical provider? \_\_\_\_ Yes \_\_\_\_ No

If yes, what is his or her name? \_\_\_\_\_

Does your child have any medical issues? \_\_\_\_ Yes \_\_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Please list any medications your child is currently taking, or has taken during the past 6 months.  
(Include prescribed and over the counter medications)

| Medication | Dosage | Used for | Prescribing Doctor |
|------------|--------|----------|--------------------|
|            |        |          |                    |
|            |        |          |                    |
|            |        |          |                    |
|            |        |          |                    |
|            |        |          |                    |



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Please share information about the substances that you know/believe that **your child** has used within the past year. Include street drugs and misuse of prescription medication.

| <b>Substance</b>                      | <b>How much and how often</b> | <b>When last used?</b> | <b>Age started using</b> |
|---------------------------------------|-------------------------------|------------------------|--------------------------|
| Caffeine                              |                               |                        |                          |
| Tobacco                               |                               |                        |                          |
| Alcohol                               |                               |                        |                          |
| Marijuana/Pot                         |                               |                        |                          |
| Cocaine/Crack                         |                               |                        |                          |
| Opiates/Narcotics (i.e. pain killers) |                               |                        |                          |
| Barbiturates/Sedatives/Tranquilizers  |                               |                        |                          |
| Amphetamines/Stimulants               |                               |                        |                          |
| Hallucinogens/LSD/Psychedelics        |                               |                        |                          |
| Other:                                |                               |                        |                          |

Please share information about substance use by **other people** who are significant in your child's life.

| <b>Substance</b>                      | <b>Relationship to Client?</b> | <b>How much and how often?</b> | <b>When last used?</b> |
|---------------------------------------|--------------------------------|--------------------------------|------------------------|
| Caffeine                              |                                |                                |                        |
| Tobacco                               |                                |                                |                        |
| Alcohol                               |                                |                                |                        |
| Marijuana/Pot                         |                                |                                |                        |
| Cocaine/Crack                         |                                |                                |                        |
| Opiates/Narcotics (i.e. pain killers) |                                |                                |                        |
| Barbiturates/Sedatives/Tranquilizers  |                                |                                |                        |
| Amphetamines/Stimulants               |                                |                                |                        |
| Hallucinogens/LSD/Psychedelics        |                                |                                |                        |



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Does your child do things that other people might think are impulsive, risky, or dangerous?

Yes  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check any of the following symptoms or concerns that your child is currently or have recently experienced:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Stress              | <input type="checkbox"/> Aggression         | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Chronic Pain        | <input type="checkbox"/> Eating problems    | <input type="checkbox"/> Gender identity    |
| <input type="checkbox"/> Loneliness          | <input type="checkbox"/> Controlling        | <input type="checkbox"/> Trouble sleeping   |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Unwanted memories  |
| <input type="checkbox"/> Relational issues   | <input type="checkbox"/> Hearing voices     | <input type="checkbox"/> Pregnancy/Abortion |
| <input type="checkbox"/> Low self-esteem     | <input type="checkbox"/> Racing thoughts    | <input type="checkbox"/> Anxiety            |
| <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Loss of control    | <input type="checkbox"/> Fears              |
| <input type="checkbox"/> Grief               | <input type="checkbox"/> Drug/Alcohol use   | <input type="checkbox"/> Panic              |
| <input type="checkbox"/> Sexual addiction    | <input type="checkbox"/> Impulsive behavior | <input type="checkbox"/> Anger              |
| <input type="checkbox"/> Poor Concentration  | <input type="checkbox"/> Sexual concerns    | <input type="checkbox"/> Bad dreams         |

If your child is a student, does he or she enjoy school?  Yes  No

If no, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your child's peer relationships like? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child want to attend therapy?  Yes  No

Any other information you think is important for me to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_