

Child Intake Form

Please provide the following information about your child:

Full Name: _____

Nick Name: _____

Birth Date: _____ Today's Date: _____

Behavioral Excesses:

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:

What does your child do that you like? What does he/she do that other people like?

Others Concerns:

Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Family History:

The name of the child's biological parents: **(required)**

Mother: _____ Father: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Who has legal custody of your child?

Copy of court order? **(Must be provided before your child will be seen)**

YES or NO

How old was your child when you divorced? _____

Who are other household members with your child?

Names	Ages	Relationship to child
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Who are your child's significant others NOT living with your child?

Names	Ages	Relationship to child
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Please describe any past counseling that either your child or any family member have had.

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____ if yes, please describe:

Education History:

What school does your child attend?

Address:

Phone: _____ Teacher's Name: _____

Current Grade: _____

What does your child's teacher say about him/her?

Other schools attended (including pre-school):

Has your child ever repeated a grade? If so which one(s)?

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

- | | | | |
|----------------|-----------------------|-------------------|-------------|
| Fighting | Lack of friends | Drug/Alcohol | Detention |
| Suspension | Learning Disabilities | Poor attendance | Poor grades |
| Gang influence | Incomplete homework | Behavior problems | |

Medical History:

What is the name of your child's primary care physician? _____

Address: _____ Phone: _____

Date of your child's last medical examination: _____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness	Other	

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal)? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?

If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child?

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____

Age: _____

Sex: Male Female

Date: _____

Relationship with the child: _____

Instructions (to the parent or guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
During the past TWO (2) WEEKS , how much (or how often) has your child...							
I.	1. Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2. Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3. Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5. Had less fun doing things than he/she used to?	0	1	2	3	4	
	6. Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7. Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8. Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9. Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10. Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11. Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12. Not been able to stop worrying?	0	1	2	3	4	
	13. Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14. Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15. Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18. Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
In the past TWO (2) WEEKS , has your child ...							
XI.	20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	22. Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
XII.	24. In the past TWO (2) WEEKS , has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	25. Has he/she EVER tried to kill himself/herself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			