

**Northshore Family Counseling, LLC**  
**Child Intake Form**

Child's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Phone: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

How does your child do in school academically? \_\_\_\_\_

How does your child do in school behaviorally? \_\_\_\_\_

Does your child have a learning or physical disability? \_\_Y, \_\_N, \_\_Maybe. Specify: \_\_\_\_\_

\_\_\_\_\_

Does your child have a mental health diagnosis? \_\_Y, \_\_N, Specify: \_\_\_\_\_

\_\_\_\_\_

Does your family have an specific spiritual beliefs? \_\_\_\_\_

**Medical History**

During pregnancy, did mother use: \_\_ Cigarettes, \_\_ Alcohol, \_\_ Drugs, \_\_ Experience Extreme Stress?

Specify frequency, amounts, and duration: \_\_\_\_\_

List any birth complications (Ex: Premature, jaundice, C-section, etc.) \_\_\_\_\_

\_\_\_\_\_

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.) \_\_\_\_\_

\_\_\_\_\_

Does child use: \_\_ Cigarettes, \_\_ Alcohol, \_\_ Drugs

Specify amount and frequency: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Last seen on: \_\_\_\_\_

Current medications: (Include dosage and frequency): \_\_\_\_\_

\_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

In the first two years, did your child experience:  Separation from mother,  Out of home care,  Disruption in bonding,  Depression of mother,  Abuse,  Neglect,  Chronic pain,  Chronic Illness,  Parental Stress

If yes, please specify: \_\_\_\_\_  
\_\_\_\_\_

Reached developmental milestones:  On time,  Early,  Late

How many times has the child moved homes? \_\_\_\_\_

What are five adjectives that describe:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Child: \_\_\_\_\_

Parental Relationship: \_\_\_\_\_

**Family History**

Biological Dad: \_\_\_\_\_ DOB: \_\_\_\_\_ Biological Mom: \_\_\_\_\_ DOB: \_\_\_\_\_

/ /  Married; / /  Separated; / /  Divorced

Siblings (1<sup>st</sup> to last): Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Custodial Adults (If not biological parents): Dad: \_\_\_\_\_ DOB: \_\_\_\_\_

Mom: \_\_\_\_\_ DOB: \_\_\_\_\_ Date became caretaker: \_\_\_\_\_

People in household, if different from above: \_\_\_\_\_  
\_\_\_\_\_

Does father work outside of the home?  Y,  N; Occupation: \_\_\_\_\_ Hours: \_\_\_\_\_

Father's highest level of education: \_\_\_\_\_

Does mother work outside of the home?  Y,  N; Occupation: \_\_\_\_\_ Hours: \_\_\_\_\_

Mother's highest level of education: \_\_\_\_\_

If separated or divorced, visitation schedule: \_\_\_\_\_

Does either parent have legal issues? \_\_\_\_\_

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.): \_\_\_\_\_

Have children witnessed domestic violence? \_\_Y, \_\_N, Specify: \_\_\_\_\_

How is your child disciplined? Please list each method and frequency of use: \_\_\_\_\_

**Trauma History**

Has your child been verbally abused? \_\_Y, \_\_N, \_\_Suspected. Specify: \_\_\_\_\_

Has your child been physically abused? \_\_Y, \_\_N, \_\_Suspected. Specify: \_\_\_\_\_

Has your child been sexually abused? \_\_Y, \_\_N, \_\_Suspected. Specify: \_\_\_\_\_

Other stressors or traumas? \_\_\_\_\_

Circle the symptoms your child displays and list the number of times per week symptom is displayed:

- |                    |                     |  |                               |
|--------------------|---------------------|--|-------------------------------|
| Anger              | Anxiety             | Bed wetting                                    | Acts out sexually             |
| Conduct problems   | Controlling         | Day defecation                                 | Has unusual sexual knowledge  |
| Day wedding        | Defiance            | Depression                                     | Homicidal thoughts or actions |
| Disassociates      | Drug or alcohol use | Hyperactivity                                  | Masturbates excessively       |
| Hyper vigilance    | Impaired conscience | Isolation                                      | Lack of empathy               |
| Lack of motivation | Lethargy            | Low impulse control                            | Plays out violent themes      |
| Low self-esteem    | Lying               | Nightmares                                     | Plays out sexual themes       |
| Obsesses           | Over/Under eating   | Phobias  | Peer problems                 |
| Phobias            | Running Away        | Shy  | Sleeplessness                 |
| Stealing           | Tantrums            | Somatic Symptoms: Headaches/Stomachaches, etc. |                               |

Other: \_\_\_\_\_

How does your child handle anger? \_\_\_\_\_

\_\_\_\_\_

Has the child experienced any significant loss? If yes, explain: \_\_\_\_\_

\_\_\_\_\_

What do you view as your child's major strengths and positive traits? \_\_\_\_\_

\_\_\_\_\_

What are your child's hobbies? \_\_\_\_\_

\_\_\_\_\_

Briefly describe your goals for your child's therapy: \_\_\_\_\_

\_\_\_\_\_

Please list any information you deem to be important for the therapist to know: \_\_\_\_\_

\_\_\_\_\_