resilient roots

Child Intake Form (to be completed by caregiver)

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

Person Completing Form: _____ Relation to the Child: _____

Child's Name: _____ DOB: _____ Male/Female: _____

Address: _____

Telephones: H: _____ Cell: _____ Work/Off: _____ Fax: _____

For Routine Messages: Phone #_____ Email: _____

For Confidential/Private Messages: Phone #_____ Email: _____

Person & Phone No. To Contact in Emergency: _____

Name of School or Childcare _____ Grade: _____ IEP? _____

Referral Source: _____

Insurance Name: _____ Carrier's Name _____

Billing Number: _____ Phone Number: _____

Presenting Problem (be as specific as you can: when did it start, how does it impact child and family): _____

_____

_____

_____

_____

Estimate The Severity Of Above Problem: Mild ____ Moderate ___ Severe ___Very Severe ____

Parents/Stepparents (name/age or year of death/cause of death, occupation, brief statement about the relationship):

Father:_____

_____

_____

Mother: _____

_____

_____

Stepparents:_____

_____

_____

Siblings and Step Siblings (name/age, if deceased: age and cause of death and brief statement about the relationship):

1. _____
2. _____
3. _____
4. _____

Additional Details About Family:

_____

_____

_____

Family history (describe any physical health issues, mental health issues, incarceration, substance abuse, violence that run in the immediate or extended family):

_____

_____

_____

Do You Have Any Concerns with Your Child's Development? (fine motor, gross motor, speech, etc.): _____

_____

_____

Medical Doctor(s) (name/phone): _____

History of Medical Problems or Hospitalizations: _____

_____

_____

Specify Medication Child is Presently Taking and For What: _____

_____

_____

Other Services, Past Or Present (speech, OT, Help Me Grow, etc.):

_____

_____

Does Your Child Have Difficulty Falling or Remaining Asleep at Night? (if yes, please explain):

_____

_____ Average Hours of Sleep Per Day: _____

Does Your Child Have Any Dietary Restrictions, Eating Issues or Allergies? (food and/or environmental):_____

_____

Estimate How Many Hours Per Day Does Your Child Spends on Screens (TV, phone/tablet, video games): _____

Supports (friendships, community, & spirituality): _____

_____

_____

Past/present psychotherapy (specify: month year(s) (beginning—end), estimated no. Of sessions, name, degree, phone & address, initial reason for therapy, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

_____

2. _____

_____

(3. *Use other side of page to add more information about psychotherapists, if needed).*

Are you involved in any current or pending legal litigation/s, lawsuit/s, children's services, or divorce or custody dispute/s? (if yes, please explain): _____

_____

What Are Your Child's Strengths? _____

_____

What Are the Strengths of the Family? _____

_____

Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.