CHILD INTAKE FORM

We appreciate the opportunity to serve your counseling needs. Please take a few moments to provide us with the following information:

Parent/Guardian Information

Date: ______________________

Parent/Guardian's Name: ____ Date of Birth: ______________

Home Address: ____ City, State, Zip: ______________

Home Phone: ____ Work Phone: ______________________

Cell Phone: ____ Email Address: ______________________

May we call you and leave messages at home? ☐ *Yes* ☐ *No* *At work?* ☐ *Yes* ☐ *No*

May we send mail to you at this address? ☐ *Yes* ☐ *No* *If not, mailing address is* ______________________________

Occupation: ____ Highest Level of Education: ____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Current Marriage: ______________

Spouse's Name: ____ Date of Birth: ______________________

Spouse's Occupation: ____ Spouse's Level of Education: ____________

Child(ren)'s Name(s): ____ Date of Birth: ______________ ☐ M ☐ F

____ Date of Birth: ______________ ☐ M ☐ F

____ Date of Birth: ______________ ☐ M ☐ F

Approximate Gross Family Income Per Year: $________________ Number of hours per week you work? ____

Name of other custodial parent: ____________________________ Phone: ____________________________

Do you have consent from the other custodial parent for treatment of child? ☐ Yes ☐ No If no, this will be required by therapist before counseling may begin.

How much contact per month does the child have with the biological mother/father? ________________________

Do you believe in God? ☐ Yes ☐ No What is your religious preference? ____________________

Are you a member of a church? ☐ Yes ☐ No If yes, what church? ______________________________

Meaningfulness of your faith/religion: ☐ Good ☐ Fair ☐ Poor

How much influence does your religion/faith have on your day-to-day activity?
☐ A Lot ☐ Moderate ☐ Little ☐ None

Emergency Contact

Name: ____ Relationship to child: ______________________________

Address: ____ City, State, Zip ______________________________

Home Phone: ____ Cell Phone: ______________________________

General Information COMPLETE ALL REMAINING INFORMATION ACCORDING TO THE CHILD COMING FOR TREATMENT

Name: ______________________ Date of Birth: ______________ ☐ M ☐ F

The child is currently living with: ______________________________________

School: ______________________ Grade: ______________________

Extracurricular activities/interests: ______________________________________

Medical History

How would you rate your child's current physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

When did a physician last examine your child? ______________ Name of Physician: ______________

Is the child currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)? ☐ Yes ☐ No
If yes, please explain: ______________________________________

____

Please list any medical conditions or disabilities for the child: ______________________

List any medications and dosage your child is now taking:

Medication(s) Over-the-counter or Prescription	Dosage

Counseling and Psychiatric History

Has the child had previous psychiatric or psychological help or counseling of any kind before? ☐ Yes ☐ No
If yes, when? ______________ For how long? ______________

Please describe reason(s) ______________________________________

Name and location of counselor: ______________________________________

Please rate the severity of your present concerns on the following scale. Check one:
☐ Mild ☐ Moderate ☐ Severe ☐ Totally Incapacitating

Who referred you to HOPE Network? ☐ Friend ☐ Church ☐ Pastor ☐ Other: ______________

I (We), the responsible party (parties), acknowledge that copies of the Declaration of Practices and Procedures, and the sliding fee scale were provided to me (us).

Client's Signature(s): ______________________ Date: ___/___/___.

______________________ Date: ___/___/___.

Reasons for Seeking help

Briefly describe your reason(s) for seeking help for your child:

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Where are these concerns causing the most problems for YOU? Please check all that apply:

☐ Home ☐ Work ☐ Marriage ☐ Other: ____________

Where are these concerns causing the most problems for the child? Please check all that apply:

☐ Home ☐ Work ☐ Marriage ☐ Other: ____________

When did the present concerns begin to be a problem for the child? ______________________________

What concerns about the child have been identified by others? ______________________________

What would you like to accomplish during this or these helping sessions for your child?

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Please indicate which of the following areas are currently problems for the child. Check all that apply:

☐ Feeling inferior to others
☐ Under too much pressure and feeling stressed
☐ Feeling down or unhappy/depressed mood
☐ Hearing voices
☐ Feeling lonely
☐ Problems at school
☐ Attention Deficit or Hyperactivity
☐ Angry feelings or outbursts
☐ Parent- child conflict
☐ Emotional abuse
☐ Concerns about physical health
☐ Physical abuse
☐ Eating and then vomiting to control weight
☐ Lacking self-confidence
☐ Loss of interest in usual activities/lack of motivation
☐ Sexual abuse
☐ Relational problems
☐ Difficulty being away from specific family members
☐ Divorce
☐ Remarriage/Blended Family
☐ Difficulty making/keeping friends
☐ Excessive fear of specific places or objects
☐ Suicidal thoughts, feelings, actions
☐ Conduct Problems
☐ Difficulty making decisions
☐ Difficulty sleeping (too much, too little)
☐ Crying spells
☐ Nightmares
☐ Loss of appetite/increased appetite
☐ Feeling fat
☐ Sexual issues
☐ Grief/loss
☐ Anxiety
☐ Argues, talks back, defiant
☐ Obsessions or compulsions with specific activities, places, objects
☐ Custody issues
☐ Other: ____

Spiritual Health

What would you say is the spiritual climate of your family unit at this time? ____

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What is your child's general spiritual condition? How much knowledge of God does your child have? In your mind, what are your child's specific "spiritual" issues? ____

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Consent for Counseling of Minors

Name of Parent/Guardian ____

Name of Minor: ____

Minor's Date of Birth ______________________Name of Counselor(s) ___________________________

This is to certify that I give permission for the minor named above to participate in the therapeutic counseling offered by HOPE Network Counseling and I agree to play an active role in this treatment as needed.

Signature of Parent/Guardian____ Date: ___________

Printed Name of Parent/Guardian____

Street Address ____

City/State/Zip ____

Home Phone: ____________________ Work Phone ______________________ Cell Phone __________________

Email address: ____

Emergency Contact (other than yourself) __________________________________Phone: ______________

If separated or divorced we need consent of all parties who share custody. Does this apply to your situation ☐Yes ☐ No

If yes, the other responsible parent must give permission below

Signature: ______________________________________ Date: ___/___/

Printed Name of Parent/Guardian_________________________ Relationship to child ____________________

This is strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited.