CHILD INTAKE FORM Today's Date: _____________

Child's Name: (First) (MI) (Last)

Birthdate: __________ Gender:

Age: _________ F M Other

Parent's Work Phone:

Parent's Work Phone:

Home/Cell Phone:

Home/Cell Phone:

Parent's Name:

Age: Occupation: Educational Level:

Parent's Name:

Age: Occupation: Educational Level:

Legal Guardian:

Child Currently Lives With:

Step-Parent(s) (if applicable):

Name of person completing form:

Please give a brief description of why you are seeking treatment:

Who referred you to our clinic?

FAMILY AND SOCIAL HISTORY

Child's Siblings:	Age	Sex	Grade	Child's Siblings:	Age	Sex	Grade

Child's Siblings:	Age	Sex	Grade	Child's Siblings:	Age	Sex	Grade

Is the child or any siblings adopted? Yes No

List all members living in the household:

If applicable give date(s) of child's parents' marriage, separation(s), and/or divorce:

If separated or divorced, what is the current parenting schedule?

Is the child currently in any childcare setting? Yes No

How much of the time (per week)?

Describe any family history of mental health or chemical dependency problems or treatment: (check all that apply)

Anxiety Depression Bipolar disorder Schizophrenia Learning disability ADHD

Alcoholism Gambling Other

Has any other member of the family ever been seen for services through BHSI? Yes No

If so, when? Which family members were seen?

____________________________ ____

List any involvement with social services, child protection, the court system or legal services:

____

Has there been any physical, emotional or sexual abuse? Yes No

SCHOOL HISTORY

Name of current school: ____ Grade: ________________

Teacher's name: ____

Previous schools _______________________________ Dates of attendance: ____

____ ____

List any special services received in schools and the grade level in which they were received: ______________________________

DEVELOPMENTAL HISTORY

Were there any problems in pregnancy, labor, birth or delivery with this child? Yes No

If yes, please give details: ____

Have there been any concerns or delays with development in any of the following areas? If yes, please indicate who evaluated the problem if help was sought.

				Evaluated By:
1.	Speech & Language	Yes	No	______________________
2.	Hearing	Yes	No	______________________
3.	Vision	Yes	No	______________________
4.	Intelligence/ability to learn	Yes	No	______________________
5.	Bladder/Bowel Control	Yes	No	______________________
6.	Emotional/Maturity Level	Yes	No	______________________
7.	Social Skills	Yes	No	______________________
8.	Eating Habits	Yes	No	______________________
9.	Fine Motor Skills (writing, coloring, etc.)	Yes	No	______________________
10.	Gross Motor Skills (walking, running, etc.)	Yes	No	______________________

4. MEDICAL HISTORY

Primary Care Clinic: ______________________ Physician: ______________________

Date of last medical examination: ______________________

Current medical problems: ______________________

List any hospitalizations or serious medical problems: ______________________

Current medications: ______________________

List any medications previously prescribed/taken: ______________________

List any drug allergies: ______________________

Do we have your permission to contact your primary care provider to assist with coordination of your care? Yes No

6. PREVIOUS TREATMENT

List any counselors seen in the past and reason for visits: ______________________

List dates of any psychiatric hospitalizations: ______________________

---

7. **CHILD PROBLEM CHECKLIST**

Please check if the child has been experiencing any of the following symptoms/behaviors currently or over the past month.

- Unhappy, sad or depressed
- Loss of interest or pleasure in activities
- Decrease or increase in appetite
- Feelings of worthlessness
- Thoughts of hurting self
- Trouble falling or staying asleep
- Bedwetting
- Impulsive/ excitable
- Fidgets excessively
- Avoids school
- Loses temper often and easily
- Defies authority
- Frequent nightmares or bad dreams
- Showing off
- Demands a lot of attention
- Cries easily and often
- Eating problems
- Easily fatigued or tired
- Difficulty concentrating
- Not wanting to live
- Panicky or anxious
- Difficulty following directions at home or at school
- Inattentive, easily distracted
- Engages in physically dangerous activities
- Unusual habits or compulsive behaviors
- Lying , stealing , destruction of property
- Acts younger than others his/her age
- Seems too dependent
- School absence
- Secretive

Worrying excessively (describe): ____

____

Problems with schoolwork (describe): ____

____

____

Problems with peers (describe):

____

____

Problems with Siblings (describe): ______________________________

____

Unusual fears (describe):

Anything else you want us to know?