HOPE – Child & Family Counseling, Inc.

Child Intake Assessment

Date: ____ / ____ / _____

Clients Name: _____ DOB: ___ /___ / _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Other (please specify): _____

Address: _____

City, State, & Zip: _____

Phone Number: (____) - _____

Current school attending: _____

Current grade level or highest education completed: _____

Parent(s)/Guardian Name(s): _____

Presenting Problem

What concerns are you having regarding your child?

_____
_____
_____
_____
_____
_____

How are these concerns impacting your child's daily life? How long have these concerns been occurring?

_____
_____

What do you hope to achieve through therapy?

_____
_____
_____

Please provide any additional information you think is important for your counselor:

_____
_____
_____

Current Symptoms your child is presenting with:

☐Abandonment issues
☐ ACOA
☐ Aggressive Physical Behavior
☐ Aggressive Verbal Behavior
☐ Alcohol abuse
☐ Anger issues
☐ Anorexia/Bulimia
☐ Anxiety/Tension
☐ Binge eating
☐ Child problem
☐ Chronic Pain
☐ Cognitive Problems (understanding, concentrating, or remembering)
☐ Compulsive gambling
☐ Concentration Problems
☐ Conduct Problems/Disruptive Behavior
☐ Decreased Appetite
☐ Delusions
☐ Depression
☐ Diet pill misuse/abuse
☐ Difficulty concentrating
☐ Difficulty with sleep maintenance
☐ Difficulty with sleep onset
☐ Diuretic misuse/abuse
☐ Fatigue
☐ Feelings of guilt/shame
☐ Feelings of helplessness
☐ Feelings of hopelessness
☐ Feelings of worthlessness
☐ Financial problems
☐ Fire setting
☐ Food concerns
☐ Food restriction
☐ Gender identity issues
☐ Grief/loss issues
☐ Hallucinations
☐ Health Concerns
☐ Homicidal thoughts
☐ Hostility
☐ Hyperactive/Impulsive
☐ Illegal drug abuse
☐ Impulsive spending
☐ Increased Appetite
☐ Increased/Decreased Appetite
☐ Insomnia
☐ Irritability
☐ Laxative misuse/abuse
☐ Legal problems
☐ Mania
☐ Marital/significant other problems
☐ Medical problems
☐ Mood swings
☐ NLP Techniques
☐ Obsessions/Compulsions
☐ Over sleeping
☐ Pain
☐ Panic attacks
☐ Paranoia
☐ Parent-child conflict
☐ Peer relationship conflict
☐ Phobias
☐ Post-trauma symptoms
☐ Prescription drug abuse
☐ Racing thoughts
☐ Relationship problems
☐ SAD – Seasonal Affective Disorder
☐ School problems
☐ Self-induced vomiting
☐ Self-mutilation
☐ Sexual compulsivity
☐ Sexual Problems
☐ Sleep Disturbances
☐ Social isolation
☐ Suicidal thoughts
☐ Tearfulness
☐ Weight Loss/Gain (significant)
☐ Work problem
☐ Other:

Functional Impairments:

☐ Daily Living (e.g., making appointments, handling money, making everyday decisions)
☐ Family Interactions/Involvement
☐ Fitness/Recreational/Leisure Activities
☐ Household (e.g., shopping, cooking, laundry, other chores)
☐ Marriage/Intimate Relationships
☐ Other:
☐ Physical Health
☐ School (e.g., academic performance, completing assignments, attendance)
☐ Self-Care (e.g., hygiene, grooming, eating right)
☐ Social Interactions/Involvement
☐ Work (e.g., completing tasks, performance level, finding/keeping a job)

Environmental Problems:

☐ Competency/Guardianship
☐ Economic Problems
☐ Educational Problems
☐ Housing Problems
☐ Problems Related to the Social Environment
☐ Problems with Access to Health Care Services
☐ Problems with Primary Support System
☐ Other:

Psychiatric History

Has your child previously accessed outpatient therapy? ☐ Yes ☐ No

If yes, please list date & provider name:
Name: _____ Date: ___ / ___ /____ to ___ / ___ / ____

Name: _____ Date: ___ / ___ /____ to ___ / ___ / ____

Name: _____ Date: ___ / ___ /____ to ___ / ___ / ____

Has your child previously accessed inpatient therapy? ☐ Yes ☐ No

If yes, please list date & facility name:
Name: _____ Date: ___ / ___ /____ to ___ / ___ / ____

Name: _____ Date: ___ / ___ /____ to ___ / ___ / ____

Name: _____ Date: ___ / ___ /____ to ___ / ___ / ____

Please indicate if your child experience or have been diagnosed with the following:

☐ Anger Management
☐ Anorexia/Bulimia
☐ Antisocial Features
☐ Anxiety
☐ Borderline Features/ Personality Disorder
☐ Conduct Disorder/Problems
☐ Depression - Bipolar
☐ Depression
☐ Dissociative Symptoms
☐ Learning Disorder
☐ Mood Disorder
☐ OCD
☐ Panic
☐ Phobias
☐ Psychosis
☐ Schizophrenia
☐ PTSD/Trauma
☐ Suicide/Self-Harming
☐ Other (specify below)

Please indicate if any family members have experienced or been diagnosed with the following:

☐ Alcoholism
☐ Alzheimer's
☐ Anger Management
☐ Anorexia/Bulimia
☐ Antisocial Features
☐ Anxiety
☐ Borderline Features/ Personality Disorder
☐ Conduct Disorder/Problems
☐ Dementia
☐ Depression - Bipolar
☐ Depression
☐ Dissociative Symptoms
☐ Drug Addiction
☐ Learning Disorder
☐ Mood Disorder
☐ OCD
☐ Panic
☐ Phobias
☐ Psychosis
☐ Schizophrenia
☐ PTSD/Trauma
☐ Substance Abuse/Addiction
☐ Suicide/Self-Harming
☐ Other (specify below)

Developmental & Educational History

Did any of the following problems occur during mother's pregnancy?

☐ Emotional stress ☐ Drug use ☐ Other (please describe)
☐ Alcohol use ☐ Cigarette use

Birth?

☐ Normal delivery ☐ Cesarean delivery ☐ Admission to NICU
☐ Difficult delivery ☐ Premature birth ☐ Complications

Infancy?

☐ Feeding problems
☐ Sleep problem

Is your child currently involved in Early Intervention or Head Start services? ☐ Yes ☐ No

Please indicate if your child experiences any of the following developmental delays:

☐ Delayed Speech ☐ Feeding Problems ☐ Stuttering
☐ Delayed Walking ☐ Fine motor ☐ Toileting Difficulties
☐ Dev. Coordination Problem ☐ Gross motor ☐ Underweight
☐ Soiling Self ☐ Reactive Attachment ☐ Other
☐ Bedwetting ☐ Separation Anxiety

Please indicate if your child experiences any of the following problems with educational functioning:

☐ Authority conflicts ☐ Learning Disorder(s) ☐ School Changes (frequent)
☐ Disorder of Written Expression ☐ Mathematics Disorder ☐ School Expulsions
☐ Dyslexia ☐ Mixed Expressive/Receptive Language Disorder ☐ School Suspensions
☐ Expressive Language Disorder ☐ Special Education
☐ Illiteracy ☐ Poor Grades ☐ Other
☐ Learning Disability ☐ Reading Disorder
☐ Receptive Language Disorder

Please indicate if your child experiences any of the following emotional/behavior problems:

☐ Alcohol abuse ☐ Fire-setting ☐ Poor Concentration
☐ Animal cruelty ☐ Frequently daydreams ☐ Repeats words of others
☐ Assaults others ☐ Frequently tearful ☐ Self-injurious threats
☐ Bizarre behavior ☐ Hostile/angry mood ☐ Self-injury
☐ Breaks things ☐ Hyperactive ☐ Stealing
☐ Chronic lying ☐ Immature ☐ Violent temper
☐ Disobedient ☐ Impulsive ☐ Other:
☐ Distrustful ☐ Indecisive
☐ Drug use ☐ Lack of attachment
☐ Easily distracted ☐ Not trustworthy
☐ Extreme worrier ☐ Often Sad

Please describe the child's relationship with teachers and any other developmental information you feel is important:

_____
_____
_____

Personal & Family History

Race/Ethnicity (optional): _____ Religion (optional): _____

Current housing situation: _____

Would you describe the home situation as:

☐ Warm and supportive
☐ Typical of most families
☐ Disorganized
☐ Single
☐ Widowed
☐ Chaotic
☐ Stressful but caring
☐ Other (please describe):
☐ Other (please describe):

Please complete the following table:

Name of Relative	Living? Yes or No	Current Age	Quality of Relationship	Living with child?
Child's mother:				
Child's Father:				
Sister(s):				
Brother(s):				
Stepparent(s):				
Other significant relationships:				

Medical History

Primary care physician: _____ Phone #: _____

Date of last doctor appointment: ___ / ___ / _____

Do you feel your/your child's current physical health is:

☐ Good ☐ Fair ☐ Poor

Please describe any current chronic or serious health problems:

Please describe any serious hospitalizations or accidents:

Please list all current medications, including the dosage and reason:

Medication	Dosage	Reason

Parent/Guardian Completing this Form:

_____ _____

(Signature) (Date)