CHILD INTAKE ASSESSMENT FORM

Kristin L. Perry, MA, MFT
Kristin's Comfy Couch Family Counseling
2558 Roosevelt Ave, Suite 201, Carlsbad, CA 92008
Telephone: 760-978-6071 Fax: 760-978-6071 Email:
kristinscomfycouch@gmail.com.com

IDENTIFYING INFORMATION
Child's name: _____
Date of birth: _____ Age: _____ Grade: _____
Race/ethnicity: _____ Religious affiliation: _____
Social security number: _____
Person(s) completing this form: _____ Today's date: _____
Who suggested that you contact me? _____
Child's custodian/guardian(s) is/are: _____
Child's Home Address: _____
City _____ State _____ Zip Code_____
Home Telephone: _____ Other Phone (specify type): _____
Is it OK to contact you/child at home? □ yes □ no OK to leave a message? □ yes □ no
Special instructions? _____
Emergency Contact Name: _____ Relationship to Child: _____
Address: _____
City _____ State _____ Zip Code _____
Home Telephone: _____ Other Phone (specify type): _____
MOTHER'S INFORMATION
Mother's name: _____ Date of birth: _____ Phone: _____
Address: _____
Race/ethnicity: _____ Religious affiliation: _____
Highest Grade Completed: _____
Marital/relationship status (Check one):
□Married □Live with partner □Single □Separated/Divorced □Widowed or □Other: _____
Employment status (Check all that apply):
□Employed □retired □disabled □student □homemaker □unemployed
If/When employed, what type of work does mother do? _____
Current employer is: _____
Years on Current Job: _____ Business Phone: _____
Is it OK to contact mother at work? □ yes □ no OK to leave a message? □yes □no
Special calling instructions? _____
FATHER'S INFORMATION
Father's name: _____ Date of birth: _____ Phone: _____
Address: _____
Race/ethnicity: _____ Religious affiliation: _____
Highest Grade Completed: _____
Marital/relationship status (Check one):
□ Married □ Live with partner □ Single □ Separated/Divorced □ Widowed or □ Other: _____
Employment status (Check all that apply):
□ employed □ retired □ disabled □ student □ homemaker □ unemployed
If/When employed, what type of work does father do? _____
Current employer is: _____
Years on Current Job: _____ Business Phone: _____
Is it OK to contact father at work? □ yes □ no OK to leave a message? □ yes □ no
Special calling instructions? _____

STEP-PARENT'S INFORMATION

Step-parent's name: _____ Date of birth: _____ Phone: _____

Address: _____

Race/ethnicity: _____ Religious affiliation: _____

Highest Grade Completed: _____

Marital/relationship status (Check one):

□ Married □ Live with partner □ Single □ Separated/Divorced □ Widowed or □ Other: _____

Employment status (Check all that apply):

□ employed □ retired □ disabled □ student □ homemaker □ unemployed

If/When employed, what type of work does father do? _____

Current employer is: _____

Years on Current Job: _____ Business Phone: _____

Is it OK to contact father at work? □ yes □ no OK to leave a message? □ yes □ no

Special calling instructions? _____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems your child is experiencing: _____

_____

_____

_____

What has happened to cause you to seek help NOW?

_____

_____

_____

What do you hope to be able to do or achieve as a result of treatment? _____

_____

_____

What do you consider to be other stresses in your child's life? _____

_____

HISTORY OF THE PROBLEM

When did your child first start experiencing the problem(s) that brought you to the clinic today? _____

_____

How often does the problem occur? _____

How long does it last? _____

Does your child have any thoughts of harming him/herself? □ No □Yes

Has your child ever attempted to harm him/herself? □ No □Yes If yes, please explain: _____

_____

Does your child have any thoughts of harming someone else? □ No □ Yes

Has your child ever attempted to harm someone else? □ No □ Yes If yes, please explain: _____

_____

Has your child ever had previous therapy/counseling of any kind? □No □ Yes

If yes, when and for how long? _____

What concerns were addressed in therapy?

_____

_____

Was this experience helpful (please explain)? _____

Has your child ever been hospitalized for emotional/behavioral problems? □ No □Yes

If yes, when/where was this: _____

_____

Has your child been prescribed medications to control emotional/behavioral problems? □ No □ Yes

If yes, please list medications, when prescribed, and by whom: _____

_____

_____

To your knowledge, has your child experimented with alcohol/drugs? □ No □Yes
Are you concerned that your child might have or be developing a problem with alcohol or drugs?
□ No □ Yes If yes, please explain: _____
_____

FAMILY

Has this child ever experienced any parental separations, divorces, or death? □ No □Yes
If yes, when? _____ How old was the child at the time? _____
Please describe the circumstances. _____
_____
If parents are separated or divorced, who has custody of this child? _____
How often does the other parent see this child?
____ Weekly or more often
____ Once or twice a month
____ Few times a year
____ Never
Please list the age and sex for each sibling (including those deceased, and step-siblings):
Age Sex Relationship to Child Living at home?
□No □ Yes
□ No □ Yes
□ No □ Yes
□ No □ Yes
□ No □ Yes
□ No □ Yes
Other than any children already indicated above and parents, who else lives in the child's household?
_____
_____
Has anyone in the child's family had treatment for emotional problems? □ No □ Yes
If yes, please briefly explain (who/when): _____
Has anyone in your family ever attempted or committed suicide? □ No □ Yes
If yes, please briefly explain (who/when): _____

FAMILY HEALTH

Describe father's present health: _____
Describe mother's present health: _____
Have any family members had any of the following (PLEASE CHECK IF YES)?
If yes, please specify family member's relationship to this child.
□ Cancer _____ □ Severe head injury _____
□ Tourette's syndrome _____ □ Cerebral palsy _____
□ Diabetes _____ □ Food allergies _____
□ Heart disease _____ □ Alcohol/drug abuse _____
□ High blood pressure _____ □ Kidney disease _____
□ Behavior disorder _____ □ Migraine headaches _____
□ Depression _____ □ Multiple sclerosis _____
□ Mental Illness _____ □ Physical disability _____
□ Mental retardation _____ □ Stroke _____
□ Nervousness _____ □ Tuberculosis _____
□ Seizures/epilepsy _____ □ Alzheimer's disease _____
□ Reading problem _____ □ Other Learning Problem _____
□ Speech/language problem _____ □ Sickle cell anemia _____
□ Attention Deficit/Hyperactivity Disorder _____
□ Sleep Difficulties _____ □ Tics _____
□ Anxiety _____ □ Bipolar Disorder _____
□ Other significant health or emotional problem: _____
What kinds of stressful events has your child experienced recently? _____
_____
_____

What kinds of stressful events have family members experienced recently? _____
_____
_____
_____

CHILD'S EDUCATION

School (name, address) Grade Age Teacher Approx. Grades
Describe any difficulties or problems your child is having in school: _____
_____
_____

CHILD'S DEVELOPMENT

Pregnancy and delivery
Was this a planned pregnancy? □ No □ Yes
Was the mother under a doctor's care? □ No □ Yes
Number of previous pregnancies/miscarriages: _____
Describe any complications that occurred during the pregnancy: _____
_____
What drugs/medications were used during the pregnancy? _____
_____
At this child's birth, what was the mother's age? _____ Father's age? _____
Length of pregnancy: _____ weeks Birth weight: ____ lbs. ____ oz.
Length of labor: _____
Child's condition at birth: _____
Mother's condition at birth: _____
Length of stay in hospital: Mother _____ days Child _____ days
Is this child adopted? □ No □ Yes If yes, please provide adoption history: _____
_____
_____
_____
Was this child breast fed or bottle fed? □ No □ Yes If yes, when was she/he weaned? _____
At what age was this child toilet trained? Days: _____ Nights: _____
Did bed-wetting occur after toilet training? □ No □ Yes If yes, until what age: _____
Did soiling occur after toilet training? □ No □ Yes If yes, until what age: _____
Describe sleep patterns or problems: _____
_____
Language difficulties? □ No □ Yes If yes, describe: _____
_____
Delays with child are walking? □ No □ Yes If yes, describe: _____
_____
As a young child, did your child have problems getting along with others? □ No □ Yes
If yes, describe:
_____
_____
Where there other problems experienced during the child's first year? □ No □ Yes
If yes, describe:
_____
_____

CHILD'S MEDICAL CARE

Child's physician: _____ Telephone: _____
Address: _____
How often does this child see a doctor? _____ Date of last visit: _____
Is this child currently on any medication? □ No □ Yes
If yes, indicate type and reason: _____
_____
Does your child have any history of the following (please check all that apply):
□ hospitalizations □ surgeries □ high fevers □ serious accidents
□ eye, ear, nose & throat problems □ digestive disorder □ head injuries □ seizures

□ loss of consciousness □ serious illness □ allergies
Please list below details of any conditions you checked above, including any additional childhood Illnesses and other medical conditions:
Condition/hospitalization Age Treated by whom? Outcome of treatment

_____

CHILD'S INTERESTS AND ACTIVITIES

Is this child involved in any extracurricular activities, such as school sports or music programs? Clubs or religious organizations? □ No □ Yes If yes, please describe: _____

_____

_____

Please describe your child's strengths and positive characteristics: _____

_____

_____

_____

_____

Other information you feel is important and wasn't asked about: _____

_____

_____

Thank you for your time completing this form.
Kristin L. Perry, MA, MFT