Maggie Roney
COUNSELOR, MS, NCC, LPC

Child Intake Form

Child Information

Child Name: _____ Date: _____
First Middle Last

Form completed by (if someone other than client): _____

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male ☐ Other: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Work: _____ Ext: _____ Cell: _____

Parent/Guardian Email: _____

Reasons for seeking services (check all that apply, **CIRCLE PRIMARY REASON**):

☐ Anger Management ☐ Anxiety ☐ Coping ☐ Eating Disorder
☐ Fear/Phobias ☐ Mental Confusion ☐ Sexual Concerns ☐ Sleeping Problems
☐ Addictive Behaviors ☐ Alcohol/Drugs ☐ School Problems ☐ PTSD
☐ Other Mental Health Concerns (specify): _____

Family Information

Relationship	Name	Age	Living	Living with You
Mother			☐ Yes ☐ No	☐ Yes ☐ No
Father			☐ Yes ☐ No	☐ Yes ☐ No
Child			☐ Yes ☐ No	☐ Yes ☐ No
Child			☐ Yes ☐ No	☐ Yes ☐ No
Child			☐ Yes ☐ No	☐ Yes ☐ No

Significant Others (e.g. brothers, sisters, grandparents, step-relatives. Please specify relationship.)

Relationship	Name	Age	Living	Living with You
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

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Parental Information

☐ Parents legally married ☐ Have parents ever been separated ☐ Have parents ever been divorced

☐ Mother Remarried Number of Times: _____ ☐ Father Remarried Number of Times: _____

Any special circumstances (e.g., raised by person other than parents, information about spouse, other children living with client, etc.): _____

Development

Are there any unusual or traumatic circumstances that affected child's/client's development? ☐ Yes ☐ No

If yes, please describe: _____

_____

Has there been a history of child abuse? ☐ Yes ☐ No

If yes, which type(s): ☐ Sexual ☐ Physical ☐ Verbal ☐ Emotional/Psychological

If yes, the abuse was as a: ☐ Victim ☐ Perpetrator

Other childhood issues: ☐ Neglect ☐ Inadequate nutrition ☐ Other (please specify): _____

_____

Any further comments about childhood development: _____

_____

Social Relationships

How does child generally get along with other people (check all that apply)?

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/Argue Often ☐ Follower

☐ Friendly ☐ Leader ☐ Outgoing ☐ Shy/Withdrawn ☐ Submissive

☐ Other (specify): _____

Sexual Orientation: _____ Comments: _____

Sexual Dysfunctions: ☐ Yes ☐ No If yes, please describe: _____

Any current or history of being a sexual perpetrator? ☐ Yes ☐ No

Spiritual/Religious

How important to you are spiritual matters? ☐ Not at All ☐ Little ☐ Moderate ☐ Very

Is the family affiliated with a spiritual or religious group? ☐ Yes ☐ No

If yes, describe: _____

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Legal

Current Status

Is the child involved in any active legal cases (e.g. traffic, civil, criminal)? ☐ Yes ☐ No

If yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Is the child presently on probation or parole? ☐ Yes ☐ No

If yes, please describe: _____

History

Traffic Violations: ☐ Yes ☐ No DWI, DUI: ☐ Yes ☐ No

Criminal Involvement: ☐ Yes ☐ No Civil Involvement: ☐ Yes ☐ No

If you responded yes to any of the above, please fill in the following information

Charges	Date	Where (City)	Results

Education

Years of Education: _____ Currently enrolled in school? ☐ Yes ☐ No

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, reading, walking, sports, exercising, fishing, etc.):

Activity	How often now?	How often in the past?

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Medical/Physical Health

- ☐ AIDS
- ☐ Diarrhea
- ☐ Neurological Disorders
- ☐ Alcohol Abuse
- ☐ Dizziness
- ☐ Nose Bleeds
- ☐ Abdominal Pain
- ☐ Abortion
- ☐ Eating Problems
- ☐ Menstrual Problems
- ☐ Allergies
- ☐ Epilepsy
- ☐ Sexual Problems
- ☐ Bed Wetting
- ☐ Fainting
- ☐ Sleeping Disorders
- ☐ Chronic Pain
- ☐ Fatigue
- ☐ Vomiting
- ☐ Colds/Coughs
- ☐ Frequent Urination
- ☐ Constipation
- ☐ Headaches
- ☐ Diabetes
- ☐ Sexual Transmitted Diseases
- ☐ Other (Please explain below)

List any current health concerns: _____

Current Medications (please list):

Medication	Dose	Purpose	Side effect

Is child allergic to any drugs? ☐ Yes ☐ No If yes, list drugs: _____

_____

Prescribing Psychiatrist/Doctor Contact Information

Name: _____ Phone: _____

Chemical Use History

Does child currently use or have a history of chemical use? If yes, briefly describe substance, amount, etc.

_____

_____

Describe how child's/client's use has affected family or friends: _____

_____

Reasons for use (check all that apply):

- ☐ Addicted
- ☐ Build Confidence
- ☐ Escape
- ☐ Self Medication
- ☐ Socialization
- ☐ Taste
- ☐ Other: _____

Who or what has helped child in stopping or limiting use? _____

Does/has someone in child's/client's family (present or past) have or had a problem with drugs or alcohol?
☐ Yes ☐ No If yes, describe: _____

Has child had withdrawal symptoms when trying to stop the use of alcohol or drugs in the past?
☐ Yes ☐ No If yes, please describe: _____

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Counseling/Prior Treatment History

Has child ever had counseling before? ☐ Yes ☐ No

If yes, describe when and the experience: _____

_____

Has child ever had suicidal thoughts or attempted suicide before? ☐ Yes ☐ No

If yes, describe: _____

Does the client/child feel suicidal at this time? ☐ Yes ☐ No

If yes, explain: _____

_____

Has child ever been hospitalized in a drug or alcohol treatment program before? ☐ Yes ☐ No

If yes, describe: _____

Has child ever been hospitalized for psychiatric or mental care before? ☐ Yes ☐ No

If yes, describe: _____

Behaviors that you notice or your child is reporting (check all that apply):

☐ Aggression	☐ Self-Esteem Issues	☐ Drug Dependence	☐ Alcohol Dependence
☐ Cyber Addiction	☐ Eating Disorder	☐ Anger	☐ Depression
☐ Elevated Mood	☐ Antisocial Behavior	☐ Disorientation	☐ Fatigue
☐ Anxiety	☐ Distractibility	☐ Gambling	☐ Avoiding People
☐ Dizziness	☐ Hallucinations	☐ Heart Palpitations	☐ Memory Impairment
☐ Sleeping Problems	☐ Body Image Issues	☐ Mood Shifts	☐ Speech Problems
☐ Hopelessness	☐ Panic Attacks	☐ Suicidal Thoughts	☐ Impulsivity
☐ Phobias/Fears	☐ Thoughts Disorganized	☐ Irritability	☐ Recurring Thoughts
☐ Trembling	☐ Judgment Errors	☐ Sexual Addiction	☐ Withdrawing
☐ Loneliness	☐ Self Injury	☐ Worrying	

☐ Other: _____

Briefly discuss how the above symptoms has led you to seek help for your child at this time and when these behaviors began.

_____

_____

_____

_____

Child Intake Form

Any additional information that would assist us in this therapeutic process?

_____

_____

_____

_____

_____

For Staff Use

Therapist's Signature_____ Date: _____