Integrative Psychology Group, LLC

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Child Intake Information Form

Child and Family Information: **Today's date:** _____

Your child's name:_____ Child's date of birth:_____

Child's nickname/preferred name:_____Child's age:_____ Child's grade in school:_____

Your name: _____Relationship to child: _____Your date of birth:_____

Are parents Married? Divorced? Separated? Never married? (Please circle) Is a parent deceased? Y/N
If deceased please indicate which parent_____

Is your child adopted?_____at what age?_____Is there contact with

the birth parent?_____Frequency? _____Age at first contact?_____

Mother's highest grade in school:_____ Current employer_____Position held:_____

History of learning or emotional difficulties? Substance abuse ?(Please specify):_____

_____

Father's highest grade in school:_____ Current employer_____ **Position held:**_____

History of learning or emotional difficulties? Substance abuse ?(Please specify):_____

_____

If child's parents are divorced pleas indicate: Visitation schedule:_____

_____

Child's adjustment to visitation schedule?_____

Family relationship history:

Your spouse's name	Your age at marriage	When divorced/widowed	Is spouse remarried?
First _____	_____	_____	_____
Second_____	_____	_____	_____
Third_____	_____	_____	_____

Significant non-marital relationships of primary caregivers:

Name of person? relationship to which parent?	Your child's age when started?	Problems from this relationship?	Reasons for ending?
First _____	_____	_____	_____
Second _____	_____	_____	_____
Third _____	_____	_____	_____

Demographics of child's current family:

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Education	Occupation

Your child lives with (please circle): Both parents / mother/father /mother and stepfather/ father and stepmother/ Grandparent/ Guardian/ Other (please specify):_____

Stepparents _____ _____ _____ _____ _____

Grandparents _____ _____ _____ _____ _____

Uncles/aunts _____ _____ _____ _____ _____

Brothers _____ _____ _____ _____ _____

Sisters _____ _____ _____ _____ _____

Other children in the family and their relationship to your child_____

J. Relationships in your child's family of origin. Please describe the following:

1.Your children's relationship with each other: _____

2. Your child's relationship with each parent and with other significant adults:

_____

_____

3. Your child's' physical health problems, chemical use, and mental or emotional difficulties: _____

_____

_____

4. Your relationship with your child and concerns that you might have: _____

_____

Abuse history: • My child was not abused in any way. • My child was abused. If your child was abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Your Child's	age	Type of abuse	By whom?	Effects on them?	Whom did they tell?
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____

Developmental and medical history

Please indicate any difficulties with pregnancy and birth of your child:_____

_____

C. Has your child experienced any developmental delays?_____

_____

Medical history:

1. Starting with your child's birth and up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had. (Describe pregnancies in section B)

Age	Illness/diagnosis	Treatment received	Treated by	Result
_____	_____	_____	_____	
_____	_____	_____	_____	_____
_____	_____	_____	_____	\
_____	_____	_____	_____	\
_____	_____	_____	_____	\

2. Describe any allergies your child has.

To what?	Reaction you have	Allergy medications you take
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List *all* medications or drugs your child takes or has taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Has your child ever been exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects
_____	_____	_____	_____
_____	_____	_____	_____

5. Medical caregivers

1. Your child's current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If your child enters treatment with me for psychological problems, may I tell your medical doctor if needed so that he or she can be fully informed and we can coordinate your treatment? • Yes • No

6. . Please list any family history of physical health problems, chemical use, and mental or emotional Difficulties:_____

_____

_____

_____

7. Other

Are there any other medical or physical problems you are concerned about? _____

_____

_____

1.Has your child ever received psychological or psychiatric or counseling services or had a psychological evaluation before? If so, please indicate:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2.Has your child ever taken medications for psychiatric or emotional problems? • No • Yes If yes, please indicate:

When?	From whom?	Which medications	For what	With what results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Referral: How did you hear about my services? _____

How did this person explain how I might be of help to you? _____

_____

_____

Chief concern
Please describe the main difficulty that has brought you to seek help for your child:

_____

_____

_____

Is there anything else that is important for me to know about your child, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper. If you will be participating in an evaluation, please indicate what information you hope the assessment will provide.

_____

_____

_____

What are you most concerned about? Of the list is issues identified on the accompanying checklist, what issues are the most urgent?

_____

_____

_____

Is there anything that I haven't asked that you think I should know about your child? Please Provide
Information_____

_____

_____

What would you most like to achieve in considering evaluation and/or treatment for your child?_____

_____

_____

_____

_____

_____

Do you have any questions, or concerns that you would like me to discuss with me?_____

_____

_____

Please note: This is a confidential treatment record. Redisclosure is expressly prohibited by law.