Lifelong Wellness

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Confidential CHILD INTAKE FORM

Please print out, *complete and bring to our first session*
OR arrive 30 minutes prior to scheduled session to complete the forms - which I will provide you. Thank you!

CHILD

NAME ____ DATE OF BIRTH_____/____/_____
(First) (Middle Initial) (Last)
Gender: □ M □ F □ Adopted □ Biological □ Foster Other ________________________

Child's **INSURANCE:** ______________________________ Authorization #____________________
Member # ____________________ Co-pay: $______.___
Home **ADDRESS**: Number______ Street ____________________________________ Apt _________
City____ ZIP ______________

PHONES: **Home** ( ) _____ -__________ **Cell** ( ) _______ - ________**Work**( ) _____ - __________
Which Phone to call: __Home __Cell __Work May I leave brief message related to scheduling? □ Yes □ No

SCHOOL NAME: ____ GRADE__________________
ADDRESS: ___________________________________ City:______________ ZIP _________

PARENT(s)/Guardian

NAME ____ DATE OF BIRTH_____/____/_____
(First) (Middle Initial) (Last)
RELATIONSHIP □ father □ mother □ guardian
Gender: □ M □ F Marital Status: □ Never Married □ Married □ Separated □ Divorced □ Widowed

ADDRESS: Number________ Street ____________________________________ Apt _________
City:____ ZIP ______________
PHONES: **Home** ( ) _____ -________ **Cell** ( ) _______ - _______ **Work**( ) _____ - __________
EMAIL: ______________________________________ **May I email you?*** □ Yes □ No

NAME ____ DATE OF BIRTH_____/____/_____
(First) (Middle Initial) (Last)
RELATIONSHIP □ father □ mother □ guardian
Gender: □ M □ F Marital Status: □ Never Married □ Married □ Separated □ Divorced □ Widowed

ADDRESS: Number________ Street ____________________________________ Apt _________
City:____ ZIP ______________
PHONES: **Home** ( ) _____ -________ **Cell** ( ) _______ - _______**Work**( ) _____ - __________
EMAIL: ______________________________________ **May I email you?*** □ Yes □ No

Referred by:____ Phone #_________________________

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OTHER HOUSEHOLD MEMBERS

Name ________________________________Date of Birth ___/____/___ Gender: □ M □ F Relationship:________

Name ________________________________Date of Birth ___/____/___ Gender: □ M □ F Relationship:________
_
Name ________________________________Date of Birth ___/____/___ Gender: □ M □ F Relationship:________

Name ________________________________Date of Birth ___/____/___ Gender: □ M □ F Relationship:________

STRESSES/CHALLENGES: Please share a few reasons therapy is being sought at this time:

____

____

____

____

____

____

____

GOALS: What would you like to see accomplished in therapy?

____

____

____

____

BEHAVIORAL HEALTH or PSYCHOTHERAPY SERVICES HISTORY

Family member(s) receiving services__________________ Therapist's name: ___________________________
Location____ Dates of services: _________to _______

Family member(s) receiving services__________________ Therapist's name: ___________________________
Location____ Dates of services: _________to _______

What is/was helpful about working with the therapist(s)? ____
____
What was not helpful in working with the therapist(s)?____
____

CHANGES: What significant life changes or stressful events has your child/family experienced recently?

____

____

____

____

STRENGTHS: What do you consider to be some of your child's/ family's strengths?

____

____

____

____

SUPPORT SYSTEMS: What family, friendships, and/or activities do you find helpful in times of need?

____

____

AFFILIATIONS: Do you have a philosophical, spiritual or religious practices ? □ No □ Yes (please describe):

____

THOUGHTS, ACTIONS, FEELINGS: Describe any thoughts, actions feelings troubling you/your child.

____

____

FINANCIAL/ HOUSING CONCERNS: Please describe:

____

____

EMPLOYMENT or SCHOOLING

Adult #1 □ father □ mother ____ Hours/week ______
Role: ________________________________
Do you enjoy your work/school? □ No □ Somewhat □ Usually □ Most of the time
What is most stressful about your current work/school? ________________________________

Adult #2 □ father □ mother ____ Hours/week ______
Role: ________________________________
Do you enjoy your work/school? □ No □ Somewhat □ Usually □ Most of the time
What is most stressful about your current work/school? ________________________________

CHILD's HEALTH INFORMATION

1. Early development: □difficult pregnancy □ difficult labor/delivery □ premature birth □severe childhood illnesses □ sat up at ____months □ walked at ___ months □ first words at ___ months □ first sentence at ___ months □ childcare or school teachers indicate learning challenges □ peer relationships strained □ bullied □ isolated
Please describe/explain:____

____

____

2. Please rate child's current physical health? □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good
Please list any current specific health problems including any allergies:

____

3. Last physical examination with his/her healthcare provider? Month______ Year______
4. Name of Pediatrician: ____Phone #:_________________________
Hospital/HMO:____
5. Sleep habits: Average hours of sleep per night: ____
□ Rarely Sleeps □ Hard going to sleep □ Wakes up /can't get back to sleep □ Nightmares
6. Difficulties with appetite or eating patterns: ____
7. What medications or supplements (vitamins, minerals, herbs, tinctures) does he/she take?

____

EMOTIONAL and BEHAVIORAL STATUS

□ sadness □ grief □ depression □ confusion □ inattention
Please describe: ____

____

____

□ anxious □ PTSD □ panic attacks □ phobias
Please describe: ____

____

____

□ anger □ irritability □ impulsivity □ hyperactivity □ lying □ physical fights □ intense arguments
Please describe: ____

____

____

School issues: □ truancy □ suspension □ failing classes □ consistently late homework or reports

Has your child ever been prescribed psychiatric medication? □ Yes □ No
Please list psychiatric medications, approximate dates taken, and check the box if they were helpful.
____ dates_ ______ to ______ □ Yes □ No
____ dates_ ______to ______ □ Yes □ No

Has your child or a family member ever been hospitalized due to mental health concerns? □ Yes □ No
Please describe: ____

____

SUBSTANCE USE of youth/teen:
Alcohol? □ Never □ Daily □ Weekly □ Blackouts □DUI □ Work disruption □ Fights
Marijuana: (vapping, smoking, ingesting) Daily: □ one □ two □ three times Weekly □one □ two □three times
Other substances/drugs:____

FAMILY SUBSTANCE USE
Have friends/family ever expressed concern for any family members' alcohol or other drug use? □ Yes □ No

ACTIVITIES

Please describe and include approximate number of **hours per day** engaged in any of the following activities:
Team Sports:____
Community/Family:____
-____
Home Chores:____
Screen time: Phone:___ Tablet___ Video Games____ T.V. ___ Other ___
Musical instruments_____ Art/Crafts/Drawing ____ Dance____ Toys____ Reading ____Singing
Other ____

FAMILY HEALTH HISTORY

Please identify if there is a family history of any of the following.
If yes, please indicate the family member(s) affected: (E.g. yourself, sibling (name/age) father, grandmother, uncle).

			List Family Member(s) Affected
ADHD	□ Yes	□ No	____________________
Arthritis	□ Yes	□ No	____________________
Alcohol/Substance Abuse	□ Yes	□ No	____________________
Alzheimer	□ Yes	□ No	____________________
Anxiety	□ Yes	□ No	____________________
Bipolar Disorder	□ Yes	□ No	____________________
Cancer	□ Yes	□ No	____________________
Child Abuse	□ Yes	□ No	____________________
Diabetes	□ Yes	□ No	____________________
Depression	□ Yes	□ No	____________________
Developmental Disability	□ Yes	□ No	____________________
Domestic Violence	□ Yes	□ No	____________________
Eating Disorders	□ Yes	□ No	____________________
High Blood Pressure	□ Yes	□ No	____________________
Learning Disabilities	□ Yes	□ No	____________________
Multiple Sclerosis	□ Yes	□ No	____________________
Obesity	□ Yes	□ No	____________________
Obsessive Compulsive Behavior	□ Yes	□ No	____________________
Panic Attacks/Phobias	□ Yes	□ No	____________________
PTSD	□ Yes	□ No	____________________
Schizophrenia	□ Yes	□ No	____________________
Suicide or Attempted Suicide	□ Yes	□ No	____________________

Other □ Yes □ No ___________________________________

Others whom child considers "family" living outside the home: (grandparents, siblings, cousins, aunts)

Name: ___________________ Age___ Relationship__________________ Frequency of contact___________

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Name: ___________________ Age___ Relationship__________________ Frequency of contact___________

Name: ___________________ Age___ Relationship__________________ Frequency of contact___________

Please add any additional information which you believe would be helpful for me to know/understand:

Thank you very much for taking the time to complete this questionnaire.
Please ***bring all completed forms with you to our first session.***