Cynthia B Lee, LPC, NCC, RPT, CPCS

Licensed Professional Counselor, National Certified Counselor, Registered Play Therapist, Certified Professional Counselor Supervisor

Fresh Start Counseling Services
326 Myrtle Crossing Dr. #200
Statesboro, GA 30458
Phone: (912) 489-7590
Fax: (912) 489-3877

CHILD INTAKE FORM
General Information

Child's Name _____

Nickname (if any) _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Age _____ Sex _____ Date of Birth _____

Who does your child live with? _____

Does he/she have any siblings _____

Referred By: _____

Parent Information

(If necessary, please indicate primary custodian and stepparent's name)

Mother's Name _____
Check One: _____Biological _____Step _____Foster

Employment _____ Employment Phone _____

Home Phone _____ Cell Phone _____

Father's Name _____
Check One: _____Biological _____Step _____Foster

Employment _____ Employment Phone _____

Home Phone _____ Cell Phone _____

INSURANCE

Primary Insurance

Insurance Name_____

Insured's Name (if different_____

Address _____

Phone Number (_____)_____Policy_____

Group# _____Date of Birth _____SSN_____

Deductible Amount _____Co-Payment _____

Secondary Insurance

Insurance Name_____

Insured's Name (if different_____

Address _____

Phone Number (_____)_____Policy_____

Group# _____Date of Birth _____SSN_____

Deductible Amount _____Co-Payment _____

* I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the past to whom accepts assignments.

_____
Signature of Patient (Legal Guardian if Minor)

* I authorize payment of medical benefits to the undersigned physician or supplier for services received.

_____
Signature of Patient (Legal Guardian if Minor)

CURRENT PROBLEMS

What problems bring your child here for a counseling? _____

_____

_____

How and when did the problem begin? _____

_____

_____

Check all that your child is currently experiencing:

EMOTIONAL:

____ Anxiety
____ Depression
____ Crying spells
____ Hyperactivity

___ Change in personality ___ Irritability
___ Frustration ___ Feelings of hopelessness
___ Anger ___ Panic spells
___ Extreme mood swings ___ Fearful

BEHAVIORAL:
___ Loss of energy ___ Excessive shyness
___ Bedwetting ___ Biting nails
___ Hurting self ___ Not listening/following the rules
___ Aggression towards others (biting, pushing, hitting)
___ Violence toward animals

EATING:
___ Increased appetite ___ Decreased appetite
___ Anorexia
___ Bulimia (self-induced vomiting or laxative use)

SLEEPING:
____ Early waking ____ Difficulty falling asleep
____ Snoring ____ Nightmares
____ Sleepwalking ____ Daytime sleepiness

INTELLECTUAL:
____ Poor concentration ____ Difficulty finding the right words
____ Slowness of thinking ____ Use of wrong/ inappropriate words
____ Problems understanding what other people say
____ Problems with reading or spelling
____ Problems with memory
____ Difficulty organizing or planning
____ Problems completing schoolwork

THOUGHT:
____ Racing thoughts ____Unusual thoughts
____ Guilty feelings ____ Recurrent Nightmares
____ Phobias ____ Suicidal thoughts
____ Recurrent thoughts of death
____ Fears of hurting others

OTHER CHILD CHARACTERISTICS

□ Argues, "talks back," smart-alecky, defiant
□ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
□ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
□ Complains
□ Dawdles, procrastinates, wastes time
□ Difficulties with parent's paramour/new marriage/new family
□ Dependent, immature
□ Developmental delays
□ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
□ Distractible, inattentive, poor concentration, daydreams, slow to respond
□ Drug or alcohol use
□ Failure in school
□ Fire setting
□ Hypochondriac, always complains of feeling sick
□ Immature, "clowns around," has only younger playmates
□ Interrupts, talks out, yells
□ Lacks respect for authority, insults, dares, provokes, manipulates
□ Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
□ Likes to be alone, withdraws, isolates
□ Lying

□ Need for high degree of supervision at home over play/chores/schedule
□ Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness,
□ Recent move, new school, loss of friends
□ Relationships with brothers/sisters or friends/peers are poor
□ Rocking or other repetitive movements
□ Runs away
□ Sad, unhappy
□ Self-harming behaviors—biting or hitting self, head banging, scratching self
□ Speech difficulties

□ Swearing, blasphemes, bathroom language, foul language
□ Temper tantrums, rages
□ Thumb sucking, finger sucking, hair chewing
□ Tics—involuntary rapid movements, noises, or word productions
□ Teased, picked on, victimized, bullied
□ Truant, school avoiding

Other Symptoms not previously mentioned**:**

_____

_____

FAMILY DYNAMICS

Please list everyone living in the home, relationship to the child, and describe relationship as Positive/Negative

Name Relationship Positive/Negative

_____
_____
_____
_____
_____

Parents are: MARRIED SEPERATED DIVORCED NEVER MARRIED

IF divorced: age of child at the time of divorce _____

If Divorced: List step parents, significant others:

_____

Please list any other family members/people who are **significant** to the child followed by the relationship to the child (maternal/paternal grandparents, aunts/uncles/ cousins)

_____
_____
_____

Are there any negative relationships the child has been affected by the counselor should be aware of?

_____
_____
_____

TRAUMA/ABUSE HISTORY

Has the child experienced any physical, sexual, emotional abuse? IF so, please describe the abuse, including perpetrator of abuse, age of the child at the time of the abuse, and current status of any legal issues_____

_____
_____
_____
_____

EDUCATION HISTORY

1. Last year completed in School? _____Present _____
2. Current School _____
3. List all schools your child has attended

School	Start/End Grade

4. Current Teacher(s)

Teacher	Subject	Is Subject Difficult?	Positive/Negative relationship (teacher)

5. Did you repeat, fail, or skip any grade(s)? If yes, which?

6. Has your child received any formal testing for behaviors displayed at school?

7. Please list or describe and learning difficulties and/or accommodations your child receives in school. Is your child placed in special education? (504/IEP)

8. Were you ever suspended or expelled from high school for academic reasons?

9. Was your child ever suspended or expelled from high school for disciplinary reasons? If yes, when?

10. How does the child get along with peers at school?

11. Current behavioral/academic concerns at or involving school?

12. How would teachers describe your child?

13. Are you currently having any difficulties with your child's school, teachers, administration? If so, please describe

MEDICAL HISTORY

Medical Physician

Primary Care Physician's Name _____
Address _____
City _____ State _____ Zip _____
Phone # _____ Fax # _____
Does the therapist have permission to exchange information with the PCP in an effort to provide coordination of care? _____yes _____no
Please list current medical/health issues your child has.

_____
_____

MEDICATIONS THAT YOUR CHILD IS CURRENTLY TAKING

Medication	Strength	Times Per Day	Physician
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Is your child allergic to any medications? Please list and describe

_____
_____
_____

PSYCHIATRIC/MENTAL HEALTH HISTORY

Has your child ever been treated for psychiatric/mental health reasons? (i.e. counseling, hospitalization, psychological evaluations) YES _____NO _____
If Yes, please complete the following:
Clinician's Name _____
Clinician's Credentials _____
Clinician's Address _____
City _____ State _____ Zip _____
Referred By _____
Have your child ever received psychological testing before: YES _____ NO _____ If yes, by whom and when? _____
Has your child ever been hospitalized for psychiatric reasons? YES _____ NO _____ If yes, by whom and when? _____
Have your child ever talked about hurting him/her self? ever attempted suicide? YES _____ NO _____
Describe:

_____
_____

Is there a family history of any of the following psychiatric problems?

	Problem	**Relative**
_____	Depression	_____
_____	Mania	_____
_____	Suicide or suicide attempts	_____
_____	Anxiety or panic attacks	_____

_____ Obsessive compulsive disorders _____
_____ Eating disorders _____
_____ Paranoia _____
_____ Schizophrenia _____
_____ Others (Be specific) _____

Counseling Goals

Please state the purpose for seeking counseling for your child: _____
_____
_____

Please state some specific, concrete goal you hope your child will achieve in counseling: _____
_____
_____

RELIGIOUS BACKGROUND

_____I do not affiliate with any religion

Please describe the role, if any, of religion in your life as an adult.
_____
_____
_____
_____

Please describe the role, if any, of religion in your child's life.
_____
_____
_____
_____

Please describe the role, if any, of religion you use in parenting your child.
_____
_____
_____
_____

Currently, how do you describe the role of religion in your life?
_____strong _____moderate _____minimal _____ none

Do you desire faith-based counseling for your child? _____yes _____no

Person completing this form:_____

Date: _____