Guiding Empathy Inc.

7755 Center Ave, Ste 1100
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CHILD INTAKE FORM

Please fill out this form for your child (12 and under), answer the questions below, and bring it to your initial intake session. Please note: Information you provide here is protected as confidential information.

Child's name: _____ Today's Date: _____
(Last) (First) (Middle Initial)

Address: _____
(Building Number and Street) (City) (State) (Zip)

Home phone: (____) _____ May we leave a message? ☐ Yes ☐ No

Cell/Other phone: (_) ___ May we leave a message? ☐ Yes ☐ No

E-mail*: _____ May we e-mail you? ☐ Yes ☐ No
*Please Note: E-mail correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

What is the relationship of person filling out this form to Client: _____

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship: _____

Home: (____) _____ Cell/Other: (____) _____

2. Name: _____ Relationship: _____

Home: (____) _____ Cell/Other: (____) _____

I give Guiding Empathy permission to contact the above emergency contacts for emergency reasons.

Initials _____

DEMOGRAPHICS

Child's Birth Date: _____ Age:_____ Gender:_____

Names of parents: Mother: _____ Father:_____

Names of Stepparents (if applicable): _____

Ethnic Background: _____

Languages: _____

Physical Disabilities: ☐ Wheelchair User ☐ Cane/Walker ☐ Deaf/Hearing Difficulties

☐ Problems w/Sight ☐ Other _____ ☐ N/A

GENERAL AND MENTAL HEALTH INFORMATION

1. What is the reason you are seeking therapy for your child? (Please describe any precipitating event(s), current symptoms and impairments in life functioning, including when the problem started and how often they experience symptoms).

_____

_____

_____

_____

_____

_____

2. Has your child previously received any type of mental health services (psychotherapy, psychiatric, services, school counselor, hospitalizations due to mental health, etc.)?

☐ No ☐ Yes, previous therapist/practitioner: _____

Please describe how long they were seen, diagnosis (if any) and the treatment method that was used (or, what they liked, or disliked, about their previous therapist).

_____

_____

_____

3. Has your child ever had suicidal thoughts or attempted suicide? ☐ No ☐ Yes

If you marked yes to the previous question, when was the last time your child had suicidal thoughts or attempted suicide?

_____

_____

_____

4. Has your child ever been hospitalized for their suicidal thoughts, aggressive behavior, homicidal thoughts, or access to lethal means? ☐ No ☐ Yes

If you marked yes to the previous question, please list the date(s), location(s) of hospitalization, and what caused the events to occur:_____

_____

_____

_____

_____

GENERAL AND MENTAL HEALTH INFORMATION (Continued)

5. Has your child ever engaged in self harm behaviors or rituals? ☐ No ☐ Yes

If you marked yes to the previous question, please list the type of self-harm your child engages in, or has engaged in, when it began, and any additional comments:

_____

_____

_____

6. Has your child ever had any trauma related experiences? ☐ No ☐ Yes

If you marked yes to the previous question, please describe the trauma that you are comfortable sharing and/or discussing (nature of trauma, when it occurred, persons involved, and impact on ability to function).

_____

_____

_____

FAMILY MENTAL HEALTH INFORMATION

7. Are you aware of any family history regarding psychiatric/mental health? ☐ No ☐ Yes
(Please list any family member that you know has had a mental health diagnosis.)

_____

_____

_____

_____

_____

8. Has anyone in your family ever committed suicide or attempted suicide? ☐ No ☐ Yes

If you marked yes to the previous question, please list who committed or attempted suicide that you feel comfortable discussing.

_____

_____

_____

FAMILY MENTAL HEALTH INFORMATION (Continued)

In the section below, please indicate if there is any family history of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, sibling, etc.).

	Please check	**List family member**
Alcohol abuse	☐ Yes | ☐ No	
Substance abuse	☐ Yes | ☐ No	
Anxiety	☐ Yes | ☐ No	
Depression	☐ Yes | ☐ No	
Mania	☐ Yes | ☐ No	
Eating Disorder	☐ Yes | ☐ No	
Obesity	☐ Yes | ☐ No	
Obsessive compulsive behavior	☐ Yes | ☐ No	
Auditory/Visual hallucinations	☐ Yes | ☐ No	
Suicide attempts	☐ Yes | ☐ No	
Trauma	☐ Yes | ☐ No	
Domestic violence	☐ Yes | ☐ No	

MEDICAL CONDITIONS AND HISTORY

9. How would you rate your child's current physical health? (Please check 1 of the boxes below.)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems your child is currently experiencing:

_____

_____

_____

10. Has your child ever had a serious past health issue that is no longer a problem? ☐ No ☐ Yes

11. If known, when was the date of your child's last medical physical?_____

12. How would you rate your child's current sleeping habits? (Please check 1 of the boxes below.)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems your child is currently experiencing:

_____

_____

_____

13. How many times per week does your child generally exercise? _____

14. What types of exercise does your child participate in? _____

_____

MEDICAL CONDITIONS AND HISTORY (Continued)

15. Please list any eating difficulties your child has been experiencing:

_____

_____

16. Does your child have any of the following types of allergies (Please list in the space provided)
☐ Drug(s) ☐ Food ☐ Contact ☐ Animal ☐ Seasonal ☐ Other

_____

17. Has your child ever been diagnosed with any developmental delays? ☐ No ☐ Yes

If yes, please list the diagnosis: _____

BEHAVIOR CHECKLIST. Please check any of the following that concern you and/or those around you (Family, Friends, Co-Workers):

Behavior:	Current	Past	**Behavior:**	Current	Past
Sadness, crying	☐	☐	Irritable	☐	☐
Loss of enjoyment of usual activities	☐	☐	Anger issues	☐	☐
Suicidal thoughts	☐	☐	Disobedient	☐	☐
Past suicide attempts	☐	☐	Problems at home	☐	☐
Self-harm or injuring self	☐	☐	Prefer to be alone or social isolation	☐	☐
Low self-worth	☐	☐	Identity concerns	☐	☐
Low self-esteem	☐	☐	Spiritual concerns	☐	☐
Low motivation	☐	☐	Hallucinations	☐	☐
Sleep problems	☐	☐	Phobias or fears	☐	☐
Tiredness, fatigue	☐	☐	Trauma flashbacks	☐	☐
Grief	☐	☐	Obsessive thoughts	☐	☐
Withdrawn	☐	☐	Mood swings	☐	☐
Excessive worry or overly concerned about things	☐	☐	Weight or appetite changes	☐	☐
Feeling panicky, anxious, nervous	☐	☐	Drug use	☐	☐
Panic attacks	☐	☐	Alcohol use	☐	☐
Restlessness	☐	☐	Problems with authority or the law	☐	☐
Trouble finishing things or disorganized	☐	☐	Frequently acting without thinking	☐	☐
Poor concentration/easily distracted	☐	☐	Other:	☐	☐
Disruptive	☐	☐			

MEDICATIONS AND SUBSTANCE USE

18. Is your child currently taking, or have taken, any prescription psychiatric medication?

☐ No ☐ Yes

If you answered yes to the question above, please list as much information about their medication as you know (Medication, Dosage, Purpose, Doctor)

_____

_____

_____

FAMILY HISTORY

19. Are or were the child's parents married? ☐ No ☐ Yes
20. Are or were the child's parents divorced? ☐ No ☐ Yes
21. Was the child adopted? If so, at what age? ☐ No ☐ Yes Age:_____
22. Does the child have stepparents? ☐ No ☐ Yes
23. Has any of the child's parents or siblings died? ☐ No ☐ Yes

If so, indicate name, cause of death, and when they died:

_____

_____

24. Are there any siblings? (please list names and ages):_____

_____

25. Please describe the quality of the child's relationship(s) with their family members, as best you can:

_____

_____

_____

_____

_____

SOCIAL, EDUCATIONAL, & PERSONAL HISTORY

26. What is the child's current living situation (Where do they live and with whom)?:

_____

_____

_____

27. Is the child spiritual or religious or been raised with specific religious beliefs? ☐ No ☐ Yes

If yes, please describe their faith or belief: _____

28. Does the child have any significant friendships? _____

_____

_____

29. What school is the child currently attending and at what grade level?

School:_____ Grade:_____ Teacher: _____

30. How are they doing in school? (Grades, Behavior, Citizenship): _____

_____

_____

31. What do they enjoy about school?_____

32. What do they dislike about school?_____

33. Are there any additional significant life changes or stressful events that have happened recently that has impacted your ability to adequately function?

_____

_____

_____

_____

_____

_____

SOCIAL, EDUCATIONAL, & PERSONAL HISTORY (Continued)

34. What do you consider to be some of your child's strengths?

35. What do you consider to be some of your child's limitations?

36. What would you like for your child to accomplish out of their time in therapy?

Additional Notes:

Availability:

Therapist Signature

Date