CHILD INTAKE FORM

Please complete this form to the best of your abilities. There may be areas that do not apply to you or your child. Please leave those areas blank or write “N/A”. This form will be reviewed with Eva Benmeleh, PhD, Licensed Clinical Psychologist.

Date: _____ Client Name: _____

DOB: _____ Age: _____

Legal Guardian: _____ Relationship: _____

Phone: _____ Address: _____

INSURANCE INFORMATION

Insurance Company: _____

Name of Insured: _____

Insured’s Member ID #: _____

Insured’s Group #: _____

PRESENTING PROBLEM

What has happened that has caused the family to seek help now? _____

What actions has the family taken to address this issue prior to coming here?

_____

When did these issues begin? _____

What are your goals for therapy? _____

Please list the strengths of your child: _____

DEVELOPMENTAL HISTORY

- Did the mother receive prenatal care? ☐ No ☐ Yes
- Was this a planned pregnancy? ☐ No ☐ Yes
- Problems with the pregnancy/delivery?
- Use of cigarettes, alcohol, illicit drugs, prescription medication during pregnancy? ____

BIRTH

- Type of delivery: _____
- Health at birth: _____weeks Weight: ____

☐ Breastfed ☐ Bottle (Formula/Pump) ☐ Combination Milestones met on time?

EARLY CHILDHOOD ISSUES

- Colic ☐ No ☐ Yes
- Excessive crying ☐ No ☐ Yes
- Delayed language development ☐ No ☐ Yes
- Unclear speech ☐ No ☐ Yes
- Eating difficulties ☐ No ☐ Yes
- Delayed motor skills ☐ No ☐ Yes
- Chronic ear infections ☐ No ☐ Yes

TOILET TRAINING

- Age began:_____Age when fully trained: _____
- Does your child wet/ soil now? _____
    - If yes, was the doctor consulted? _____
    - How often does this occur? _____

FAMILY HISTORY

- Please provide the names and ages of persons living in the home:
  Name, Age, and Relationship:

_____

_____

_____

- Please provide the client's place of birth: _____
- If emigrated to the USA, when and under what circumstances? _____
- Education and occupation of parents: _____
- Mental health concerns in family members? If so, please describe: _____

Please describe the relationship with siblings:

□ No siblings □ Good Communication □ Argue Sometimes □ Supportive/Helpful □ Angry/Resentful □ Argue Frequently □ Respectful / Loving □ Distant □ Physical Fights □ Domestic Violence □ No-Contact

Please describe the relationship with parents:

□ Good Communication / □ Argue Sometimes □ Supportive/Helpful □ Angry/ Resentful □ □ Argue Frequently □ Respectful / Loving □ Distant

Parental marital status:

☐ Married ☐ Never Married ☐ Divorced

If divorced, type of parenting plan (time-sharing arrangement)? _____

Have parents remarried or are dating? _____

Who cares for the child while caregivers are at work or gone? _____

DISCIPLINE/ PARENTING STYLE

- Who generally disciplines the client: _____
- What method (s) of discipline do you use?

Ignore / Time-out / Warning / Loss of Privileges / Argue / Sent to Room / Earn Privileges / Praise good behavior / Yell / Compromise / Spanking / Consistent Limit Setting

- Does discipline work? _____
- Do all caregivers agree on discipline method(s)? _____
- Any current issues affecting the family? (i.e., divorce/separation, medical concerns, financial problems, recent moves) _____
- Family history of a mental, psychological, or academic problem? Please explain:

  _____

DAILY ACTIVITIES

- Sleep patterns / bedtime routine: _____
- Eating habits: _____
- Routine of activities/homework: _____

MEDICAL HISTORY

- Are medical exams up to date? _____
- Does your child take medications currently or in the past?
    - If yes, please state reason, prescribing physician, dosage, and any side effects: _____
- Allergies?

  ☐ No ☐ Yes Specify:
- Has your child ever experienced head injuries, seizures, hospitalizations, surgery, or loss of consciousness? If yes, please explain: _____

PREVIOUS EVALUATIONS/THERAPIES

Type _____

Name of Provider _____

Reason _____

Date _____

EDUCATIONAL HISTORY

Current school: ☐ Public ☐ Private ☐ Charter ☐ Home

School Name: _____

Phone number: _____

Grade:_____ Teacher's name: _____

Please list all schools your child has attended (include nursery/daycare if applicable): Name: _

_____

City: _____

Grade: _____

Reason for Leaving: _____

Does your child receive special education services? _____

What grades does your child earn in class (FCAT. SAT)? _____

Has your child ever repeated a grade? If yes, which? _____

Has your child ever received tutoring? If yes, for what and how long? _____

Does your child state if she/he likes/dislikes going to school? _____

What are your child's favorite/ least favorite subjects? _____

Is there any family member who has/had learning difficulties/ attentional difficulties, or was in special classes? If yes, who and what kind/type? _____

Has your child experienced any of the following at school?

Problem	Preschool	Elementary
Separation difficulties		
Peer relationship problem		
Problems with authority		
Learning disabilities		

SOCIAL HISTORY

Does your child participate in any special interests, hobbies, sports? _____

Concerns with your child's social life? _____

How many friends does your child have? _____

SEXUAL DEVELOPMENT

Puberty: _____

Girls: Age at first menstruation: _____

Problems associated with menstrual cycle? ☐ No ☐ Yes

Sexually active? ☐ No ☐ Yes

ABUSE HISTORY

History of neglect, sexual or physical abuse: ☐ No ☐ Yes If yes, was the neglect or abuse reported? ☐ No ☐ Yes Approx. date of incident: _____

Approx. date report was filed: _____

Relationship of abuser to client: _____

Outcome of report: _____