The Family Room Psychotherapy Associates

CHILD INTAKE

Date:____/_____/_____

Name:_____Date of Birth:____/____/_____Age:_____Sex: M F

PRIMARY LANGUAGE: Child ☐ English ☐ Spanish ☐ Other _____
Parents ☐ English ☐ Spanish ☐ Other _____

Address:_____

City/State/Zip:_____

Phone: Home: (_____)_____-_____ Work:(_____)_____-_____ Cell:(____):_____-_____

E-mail: _____Phone number to call for session reminder:(_____):_____-_____

Emergency Contact: Name:_____ Phone:(____)_____-_____

Presenting Problem: _____

_____

FAMILY HISTORY

Place of Birth: City _____ State _____ Country _____

PARENTS: __Married __Never Married __Separated __Divorced (child's age at divorce: _____)

Father's Name:_____ Lives w/Patient? **Y N** Date of Birth: ___/_____/_____

Mother's Name:_____ Lives w/Patient? **Y N** Date of Birth: ___/_____/_____

Step Parent:_____ Lives w/Patient? **Y N** Date of Birth: ___/_____/_____

SIBLINGS Name	Age	Lives with Patient?
1.		**Y N**
2.		**Y N**
3.		**Y N**

4.		**Y N**
5.		**Y N**

History of Physical Abuse/Family Violence or Neglect: ☐ No ☐ Yes Has abuse been reported? ☐ Yes ☐ No
Charges Pending? ☐ Yes ☐ No Patient was: ☐ Victim ☐ Perpetrator
Explain:_____

_____

History of Sexual Abuse/Trauma: ☐ No ☐ Yes Has abuse been reported? ☐ Yes ☐ No
Charges Pending? ☐ Yes Patient was: ☐ Victim ☐ Perpetrator
Explain_____

_____

History of Violence: ☐ No ☐ Yes, toward: ☐ People ☐ Property ☐ Other: _____
Explain:_____

Gang Involvement: ☐ No ☐ Yes, patient was/is: ☐ Victim ☐ Participant ☐"Wanna Be"
Charges Pending? ☐ No ☐ Yes, explain: _____

_____

History of Cruelty to Animals and/or Fire Setting: ☐ No ☐ Yes, explain: _____

_____

History of Risk Taking Behaviors, General Behavioral Problems or Unusual/Bizarre Behaviors: ☐ No ☐ Yes
Explain (provide time frames/dates): _____

_____

Previous In/Outpatient Treatment and Response To: _____

_____

MEDICAL & DEVELOPMENTAL HISTORY

DEVELOPMENTAL HISTORY:
Pregnancy: ☐ Planned ☐ Unplanned Reaction to pregnancy: _____

Pregnancy, Labor and Delivery: ☐ Normal ☐ Complications, describe: _____

_____

Medications or drugs used during pregnancy: _____
Description of Child as a Baby: _____

_____

Diagnosis, if any: _____

Date Diagnosed: _____ **Child's Age at Diagnosis:** _____

Has your child had head injuries: ☐ **No** ☐ **Yes, explain:** (please include dates): _____
_____

Name of Pediatrician/Family Practitioner: _____

Address: _____

Phone: _____

Name of Psychiatrist (if applicable): _____

Address: _____

Phone: _____

Describe Disciplinary Methods: _____
_____

Describe Sleeping Arrangements: _____
_____

Family History of significant Medical Conditions/Illnesses: _____
_____

Family History of Alcohol/Substance Abuse: _____
_____

Family History of Psychiatric Illness: _____
_____

Toilet Training: ☐ Normal ☐ Not Achieved Age when achieved: _____

Eating Habits: ☐ Normal ☐ Irregular, describe: _____

Sleeping Habits: ☐ Normal ☐ Irregular, describe: _____

Has your child had surgery or head injuries? ☐ No ☐ Yes, explain (include dates): _____
_____

Current medications:

1. _____ Dose:_____ For:_____
2. _____ Dose:_____ For:_____
3. _____ Dose:_____ For:_____

CURRENT THERAPY OR SERVICES:

Please list all current services your child receives on a weekly basis.

THERAPY	DATE STARTED	NUMBER OF SESSIONS EACH WEEK	TOTAL MINUTES PER WEEK	THERAPIST NAME OR AGENCY AND PHONE NUMBER
Occupational Therapy				
Speech Therapy				
Physical Therapy				
Behavior Therapy				

If your child has been diagnosed with (or you suspect)a developmental disorder, please complete the following section

Check the statement that applies to your child:

____ My child's development was apparently normal until about 18 months of age.
____ My child's development was apparently normal until about 24 months of age.
____ My child's development was atypical from birth (I/we noticed that something was wrong in the first few months).

Developmental Milestones: Please check all that apply

Qualitatively Impaired Social Interaction:
____Impaired eye-to-eye gaze & gestures
____Poor relationships with peers for age
____Limited shared enjoyment with others
____Lack of social or emotional reciprocity

Qualitatively Impaired Communication:
____ Delay or lack of verbal language
____ Poor ability to initiate or sustain conversation
____ Stereotyped or repetitive language use
____ Lack of spontaneous make-believe play
____ Poor social imitative play

Restricted, Repetitive, & Stereotyped Behavior:
____ Preoccupation or restricted patterns of interest
____ Inflexible and non-functional routines or rituals
____ Repetitive motor mannerisms (flapping, twisting, etc.)

ACADEMIC HISTORY

Type of Program: __Typical __ Special Needs __Therapeutic Program

Current School: _____ **Current Grade:**_____

Teacher Name: _____ **Phone:** _____

History of school behavioral problems or truancy: ☐ No ☐ Yes, explain: _____

_____

History of separation anxiety or school phobia: ☐ No ☐ Yes, explain: _____

_____

Academic performance: ☐ Excellent ☐ Satisfactory ☐ Unsatisfactory, explain: _____

_____

History of repeating grade(s): ☐ No ☐ Yes, explain: _____

_____

Previous Academic Placements:

SCHOOL NAME	DATES ATTENDED	TYPE OF PROGRAM	REASON LEFT

Completed By: _____ Date: _____
PRINT NAME

_____
SIGNATURE

Relationship: __Mother __Father __Guardian