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Client Intake Form

➔*All of the information that you provide in this intake is confidential and cannot be released without your consent.* ➔

Help me to know a little about you and what brought you to my office by filling out the following form. It is important that you be completely honest and that you take the time to answer every question as thoroughly as possible. By answering these questions you'll insure that we don't waste the first few sessions covering "the basics." You'll feel better understood, and it will help me make the most of my time with you.

Identifying Information

Your Name__________________ Relationship to Child______________ Your Birth Date____/____/______

Child's information:
Name________________________ Birth Date: ____/____/______ Age_______

If client is a minor:
Grade Level_____ Name of School attended:______________________
Home Phone: ( ) ______-_______ Work: ( ) ______-_______ ext. __________

Address ________________________________ City _____________ ST _____ ZIP_____________

Presenting Problem

- Please describe what prompted you to make this appointment:

____

____

____

____

- What would you like to come out of us working together?

____

____

- What is your best guess of how long it should take to accomplish this? ____________________
- What is the first thing that you will notice that will let you know that things are getting better?

____

____

- What have you tried thus far to address this problem? ______________________________________

____

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____

- What do you think has stopped or is stopping you from successfully addressing this problem?

____
____
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Health Information

Note: It may be hard to remember some of the following information, especially if your child is now a teenager. All of the information is very important, so please try to answer as completely as you can.

For Birth Parents:

- Were there any complications with your pregnancy ? Y N *(please circle one)*
  If “yes,” please explain:
  ____

- Mother’s health during pregnancy (describe any illnesses or complications):
  ____
  ____

- Were there any complications during the delivery? Y N *(please circle one)*
  If “yes,” please explain:
  ____
  ____

- Was child premature? Y N *(please circle one)*

  Height and Weight at birth ___________inches ____________ pounds

For all Parents and Guardians:

- Was your child doing the following things by the ages listed below?

My Child:	At this Age:	(circle one)	
Sat up without support:	(5-8 months)	Y	N
Made 2-syllable word sounds: (ma-ma, da-da)	(7-9 months)	Y	N
Stood without holding onto something:	(10-14 months)	Y	N
Said First *full* word by:	(11-14 months)	Y	N
Walked:	(11-15 months)	Y	N
Said 2 word sentences by: (%go home+or %want that+)	(20-25 months)	Y	N
Fed self with a fork/spoon:	At or before 2 years 3 months?	Y	N
Helped when being dressed :	At or before 4 years?	Y	N
Was Toilet trained :	At or before 3 years 3 months?	Y	N
Dressed self:	At or before 6 years?	Y	N

- Does your child have a best friend Y N Age of best friend _______
- Your child attends *(Circle any that apply)*:

  Daycare Preschool Elementary school Middle School High school College

- In general, how does your child get along with peers that are: (circle one)

  1. The same age? Very Poor Poor Well Very Well
  2. Younger children? Very Poor Poor Well Very Well
  3. Older children? Very Poor Poor Well Very Well
  4. Adults? Very Poor Poor Well Very Well

- Starting with childhood and proceeding up to present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures. And any other medical conditions your child has.

Age	Illness/Diagnosis	Treatment	Treated by	Result

- List all medications you are currently taking: (prescribed, over the counter, and others)

Medication:	**Dosage:** *(how much you take)*	**Taken for:**	**When started**	**Prescribed by:**

- Client's current family or personal physician or medical agency:

  Name_________________ Address________________________________ Phone________________
  Name_________________ Address________________________________ Phone________________

- How many hours of sleep does your child usually get per day__________
- Any difficulty falling or staying asleep? Y N *(circle one)*
- Does client usually feel or seem rested when he/she awakes Y N *(circle one)*
- How is your child's energy level? ____
- How is your child's appetite (desire to eat)? ____

- Has there been a change in appetite? *(circle one)* Increase Decrease No change
- How much/what does client typically eat? ___________________________________

Mental Health Information

Please list any prior mental health treatment or psychological testing conducted not listed in the health section of this form:

Age	Illness/Diagnosis	Treatment	Treated by	Result	Why did treatment end

- Check all that apply to your child:

☐ Depressed	☐ Anxious	☐ Friendly	☐ Confused	☐ Irritable
☐ Overweight	☐ Shy	☐ Procrastinating	☐ Helpful	☐ Precise
☐ Shallow	☐ Outgoing	☐ Underweight	☐ Inept	☐ Proud
☐ Weak	☐ Distant	☐ Low self-esteem	☐ Sarcastic	☐ Self-doubting
☐ Helpless	☐ Lost	☐ Hopeless	☐ Short-fuse	☐ Dependable
☐ Hopeful	☐ Poor memory	☐ Poor concentration	☐ Hyper-active	☐ Guilty
☐ Tough-skinned	☐ Caring	☐ Secretive	☐ Passive	☐ Overwhelmed
☐ Bizarre	☐ Grieving	☐ Empty	☐ Sad	☐ Distant
☐ Self-critical	☐ Jolly	☐ Forgiving	☐ Nervous	☐

- Has your child been or is he/she now the victim of or witnessed:

Domestic spousal abuse/violence	Y	N
Physical abuse	Y	N
Emotional abuse	Y	N
Sexual abuse or assault	Y	N

If the answer to any of the above questions about abuse is "yes;"

- Was the abuse reported Y N (*circle one)*
- What was the outcome of reporting it? ___________________________________

____

____

- Is the abuse still going on? Y N (*circle one)*
- Has your child ever discussed or attempted suicide Y N (*circle one)*
- If so, please describe: ___________________________________

____

____

- Is there a family-history of mental health concerns or treatment Y N (*circle one)*
- If so, please describe: ___________________________________

____

____

____

Educational Background

Please list all schools that your child has attended, starting with current or most recent:

Dates: (from date-to date)	School Name:	Special Classes:	Grades: (A,B,C,D,F's)	Graduate?
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In general, how does (or did) your child do in these areas in school: (circle one)

1. Adjustment to school? Very Poor Poor Well Very Well
2. Academics? Very Poor Poor Well Very Well
3. Peers? Very Poor Poor Well Very Well
4. Teachers, Principals, or Professors? Very Poor Poor Well Very Well
5. Extra Curricular involvement? Very Poor Poor Well Very Well

School Disciplinary History

Dates: (from date-to date)	Type of Action:	Taken By:	Outcome:
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Is there anything else youød like me to know about your childøs current school situation that wasnøt covered above?

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Family Information

Family-of-Origin history

Name of Relative:	Current age: *(Or age at death)*	**Cause of death, if deceased:**	How do your child and this relative get along?
Father:			
Mother:			
Stepfather:			
Stepmother:			
Foster Father:			
Foster Mother:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Other Relatives:			

Fatherøs occupation________________________ Education___________________
Motherøs occupation________________________ Education___________________
Stepfatherøs occupation______________________ Education___________________
Stepmotherøs occupation_____________________ Education___________________

Current Family Structure

- Please list all individuals who currently live with your child. Include any information about foster home placement, or custody arrangements for separated/divorced parents.

____
____
____
____

CURRENT FAMILY INCOME (annual):

☐Below $10,000 ☐10,000—25,000 ☐25,001—50,000 ☐50,001—75,000

☐75,001--100,000 ☐100,001—150,000 ☐Above 150,000

For the parent or guardian: Marital/Relationship History

Please include information regarding significant romantic relationships.

1. Current or most recent (*circle one)*: Spouse Partner

How long have you:

- Been married? From ______ to______ (*if divorced how long were you married*?)
- Lived together from ______to______, dated from________ to________

How did you and your spouse/partner meet? ____

____

____

Describe your relationship: ____

____

Positive things about your spouse ____

Negative things about your spouse ____

If divorced, what lead up to it? ____

____

____

- Previous (*circle one)*: Spouse Partner

How long have you:

- Been married? From ______ to______ (*if divorced how long were you married*?)
- Lived together from ______to______, dated from________ to______

How did you and your spouse/partner meet? ____

____

Describe your relationship: ____

____

Positive things about your spouse ____

Negative things about your spouse ____

If divorced, what lead up to it? ____

- Previous (*circle one)*: Spouse Partner

How long have you:

- Been married? From ______ to______ (*if divorced how long were you married*?)
- Lived together from ______to______, dated from________ to______

How did you and your spouse/partner meet? ____

____

Describe your relationship: ____

____

Positive things about your spouse ____

Negative things about your spouse ____

If divorced, what lead up to it? ____

Other Children:

Please provide the following for other biological or adopted children who currently live in your home:

NAME:	DATE OF BIRTH:	AGE:	SEX:	SCHOOL:	GRADE:	DIFFICULTIES OR PROBLEMS:
			M F			
			M F			
			M F			
			M F			
			M F			

Please provide the following for biological or adoptive children who **do not currently live in your home:**

NAME:	DATE OF BIRTH:	AGE:	SEX:	SCHOOL:	GRADE:	DIFFICULTIES OR PROBLEMS:
			M F			
			M F			
			M F			
			M F			
			M F			

Legal History:

Please list any situations that have brought you in contact with the legal system, law enforcement, or the courts

Date or approximate age	Describe the situation	Outcome

Lifestyle

Alcohol and Drug Use

The following questions concern only your child's use of alcohol and drugs. You will receive a separate form to fill out for yourself and other family members if necessary.

Please indicate your use of the following (unless listed under medications):

Name	Age when first used	Most used at one time	Current use	Last time used	If use has ended, why
Caffeine					
Nicotine					
Alcohol					
Amphetamine (speed, uppers)					
Depressants (xanax, Klonopin)					
Inhalants (whip-its, paint, glue)					
Marijuana (pot, weed)					
Narcotics (Vicodin, Oxycotton, Percocet, heroin)					
Cocaine (blow, crack)					
Methamphetamine ***(meth, crank, ice, glass, crystal)***					
Ecstasy					
Other					

Have anyone complained about your drinking/drug use? Y N Who _______________

Have you ever felt guilty over your drinking/drug use? Y N

Do you typically have a drink to get going in the morning? Y N

Have you ever consumed alcohol while working without approval of you employer? Y N

Have your drug/alcohol use resulted in problems at work, home, or personal life? Y N

Have you ever blacked out from alcohol/drug use? Y N More than 3 times? Y N

How many times have you been *charged* with DUI/OVI ______

Religious/Spiritual Beliefs

Childhood: ____

Current: ____

____

To what degree do spiritual and religious beliefs impact you? *(circle one)*

Not at All. A little. A lot. Extremely.

Thank you for taking the time to fill out this form. All information contained within is confidential and can only be released with a valid and signed release of information.

W.D. Kennedy, Psy.D. OH Lic. # 5171