HOPE FOR THE SOUL

Child Client Intake Form

Child's Name____Age______ Date___/___/______
Parent assisting in filling out form _________________________ Relationship to client____________
How did you hear about us? ____
What prompted your visit?____
____
____
How long have you been aware of your child struggling with this issue/concern? ______________
What are three goals/areas do you wish counseling to address?

1. ____
2. ____
3. ____

What are your child's greatest strengths? ____
____

Educational Background

What is your child's current grade level? ________ School attended ______________________
Does your child have any special academic or social needs in school? ______________________
____
What are your child's favorite school subjects? ____
What are your child's biggest struggles in school? (academic, peer pressure, homework, attention in class, etc) ____
____
Is there anyone in your child's school that you would like your counselor to be in touch with?
____

Mental/Medical History

Has your child ever received counseling services before?

Counselor Name	Dates	Reason	Outcome

What approaches have you tried in the past on your own?___________________________
____
Were any of them successful? ____
Please list any medication your child is currently taking or have taken in the past:

Medication	Dates	Dosage	Reason	Physician

Date of last medical examination ____/_____/_______ Primary Physician __________________
Address ____ Phone __________________
Please rate your child's health: Excellent_____ Good _____ Fair _____ Declining _____ Poor _____

Please list all current or previous illnesses, injuries, handicaps, hospitalizations, medical concerns:
____
____
____

Have you noticed any disturbance in your child's sleep, weight, eating habits, mood, concentration, energy, memory, social interactions, and daily functioning? Please describe:___________________________
____
____

Please describe your child's current sleep and eating habits ______________________________________
____

Social/Family Background

Is your child's father living? Y N Age______ Marital Status _________ Date of Death _______________

Please describe your child's current and past relationship with their father: ______________________
____
____

Is your child's mother living? Y N Age_______ Marital Status __________Date of Death _______________

Please describe your child's current and past relationship with their mother: ______________________
____
____
____

What is your child's relationship with their sibling(s) like?___________________________________
____

Please describe any mental illness, medical problems, handicaps, addictions, or abuse in your family history: ____
____
____

Please include any family history, patterns, or significant information that you feel would be helpful in treating your child____
____

Current Family Composition

Please indicate your current family composition, incl. step/half/adopted, etc:

Name	Relationship	Age	In Home (Y/N)

What stressors is your family currently facing?____
____
____

What stressors has your child overcome? Please include both family and social circumstances.
____
____

What significant losses has your child experienced? ____

____

Who does your child confide in?____

Does your child appear to be currently satisfied with their current friendships? Y N Please explain:

____

____

What fears or concerns does your child have? ____

____

What are your child's favorite things to do on their own? _______________________________

____

What are your child's favorite things to do with others? ________________________________

____

Abuse/Victimization Issues

Has your child ever felt like hurting themselves or someone else? If yes, please describe:

____

Has your child ever felt suicidal? ____

____

Did they have a plan? If yes, please describe: ____

Did they have the means to carry out their plan? ____

Have they ever attempted suicide? If yes, when, and how? __________________________________

____

Was your child ever hospitalized for suicidal ideation or behavior? If yes, when?_______________

____

Has your child ever been an abuser/been abused? Please describe briefly what happened, who the abuser was, and when it happened:

Physically ____

Emotionally____

Sexually____

Verbally____

Spiritually ____

Financially____

Did your child tell anyone? ______________________ What were the results of telling?

____

Faith Background

Does your family currently practice any religion or have spiritual beliefs? Y N If so, please describe:

____

Does your child believe in God? Y N Do you pray together? Y N

Do you go to church? Y N If yes, how often? ____

Would you like spirituality/faith to be a part of the counseling process? Y N If yes, please describe:

____

____

Additional Information

Please include any other helpful information you would like your counselor to know about your child:

____

____

____

____