CW Counseling and Consulting, LLC

CHILD INTAKE FORM
(Please complete in Ink)

2400 Second Loop Road
Florence, South Carolina 29501
Office: (843) 667-1905 Fax: (843) 667-1723

CHILD

1. Child's Name _____ Sex_____ Age_____ DOB_____

2. Natural Child Yes / No If adopted, at what age_____ Foster since _____

3. Parents' Names (include stepparents, foster parents, etc.

_____

4. Comments about custody and visitation (if applicable):

_____

_____

5. What is the primary reason you are concerned about your child?

_____

_____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

a. _____ Sleep problems
_____ Lack of interest in activities
_____ Unassertive
_____ Fatigue/low energy
_____ Concentration problems
_____ Appetite/weight changes
_____ Withdrawal

_____ Morbid thoughts
_____ Suicidal thoughts or threats
_____Suicidal plans/attempts
_____Mood swings
_____ Depression
_____Changed level of activity
_____ Cries easily

b. _____ Forgetful/memory problems
_____ Short attention spans
_____ Aggressive behavior
_____ Can't sit still
_____ Not interested in peers
_____ Picked on / bullied by peers
c. _____ Excessive worry/fearfulness
_____ Anxiety or panic attacks

_____ Talks excessively / interrupts
_____Easily distracted
_____ Irritable
_____Impulsive
_____Difficulty following rules
_____ Problem completing schoolwork
_____ Nightmares
_____Frequent tantrums

_____ Social fears, shyness
_____ Separation problems
_____ Bedwetting/soiling
_____Headaches, stomachaches
_____Odd beliefs / fantasizing

_____ Resistive to change
_____ School refusal
_____ Perfectionism
_____Odd hand / motor movements
_____ Hallucinations

d. _____Lying
_____Trouble with the law
_____Running away
_____ Truancy, skipping school
_____ Hurting others sexually
_____ Alcohol/drug use
_____ Argumentative/defiant
_____ Swears
_____ Blames others for mistakes

_____Stealing
_____ Being destructive
_____ Fire setting
_____ Hurting others / fighting
_____ Acts as if he/she has no fear
_____ Short-tempered
_____ Easily annoyed/annoys others
_____Discipline problem
_____ Angry and resentful

BROTHER AND SISTERS

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

SCHOOL HISTORY

1. Present School: _____Grade: _____ Teacher: _____
2. Has the child ever repeated any grade? _____
3. Does the child receive special education services? No _____ Yes, what kind? _____
4. Please describe academic or other problems your child has had in school

_____

_____

_____

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CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. **Pregnancy**

Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____

Delivery: Normal _____ Breech _____ Cesarean _____ Transectional _____

Full-term _____ Premature _____if premature, number of weeks _____Birth Weight: _____

Problems at birth: (for example, the infant was given oxygen, blood transfusion, placed in an Incubator, etc.) _____

_____

2. **Developmental History**

- State the approximate age when the child did the following:

  Walked alone _____ Said first word _____ Used 2-word phrases _____

- Understood and followed simple directions _____
- Reasonably well toilet trained _____
- Did the child cry excessively? _____ Rarely cried _____

3. **Health History of Child**

In the first two years, did your child experience: _____Separation from mother, _____Out of home care, _____Disruption in bonding, _____Depression of mother, _____Abuse, _____Neglect, _____Chronic pain, _____Chronic Illness, _____Parental Stress

- Child's Doctor: _____
- Date of last physical exam: _____
- Vision problems? Yes _____ No_____ Hearing problems? Yes _____ No _____
- Dental problems? Yes _____ No _____

- Any head injuries or loss of consciousness? Yes. _____ No _____
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No_____ Yes _____describe and give dates _____

- Is your child currently taking any medications? No _____ Yes _____name medications

  _____

  _____

  Name of Doctor who prescribes meds: _____

- List any medicines previously used for emotional problems: were they helpful? _____
  _____
- Allergies to drugs or medicines? No _____ Yes _____ (list) _____
- Allergies to any foods? No _____ Yes _____ (list) _____
- Are there any foods that you limit or do not give this child? No _____ Yes _____ (list)
  _____
- Allergies to environmental conditions? No _____ Yes _____ (list) _____
- Does anyone in the household smoke? No _____ Yes _____
- About how many hours does this child watch TV, videos, etc. per day _____
- Are you afraid someone you know may injure/harm this child? No _____ Yes _____

National Domestic Violence Hotline 1-800-799-7233

- Does this child have a Health Care Directive? No _____ Yes _____

  If yes, please list where (clinic) it is on file _____
- Any previous psychological or psychiatric treatment? No _____ Yes _____

  Whom/where _____when_____
- Any previous testing (school/psychological)? No _____ Yes _____

  Whom/where _____when_____
- Do you think your child's use of chemicals is a problem? No _____ Yes _____

  Type: Alcohol _____ Marijuana _____ Other drugs _____

Family History:

Chemical use (now & past): No _____ Yes _____ Which parent _____

Type: Alcohol _____ Marijuana _____ Other drugs _____

List any history of mental illness or addiction in immediate or extended family (Ex:

Depression, anxiety, bipolar disorder, suicide attempts, alcoholism, drugs, ADHD,

Schizophrenia, etc.): _____

_____

Has the child witnessed domestic violence? _____Y, ____N, Specify: _____

_____

How is your child disciplined? Please list each method and frequency of use: _____

_____

_____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? __Y, __N, __Suspected. Specify: _____

_____

2. Has your child been physically abused? __Y, __N, __Suspected. Specify: _____

_____

3. Has your child been sexually abused? __Y, __N, __Suspected. Specify: _____

4. Other stressors or traumas? _____

What are your child's strengths? _____

Any additional comments or information that would be helpful to us? _____

The person's signature is required to complete the form for the relationship with the patient.:

Name _____ Relationship _____ Date_____