Child Intake Form

IDENTIFYING INFORMATION

Child's Name:_____
Date of birth: _____ Age:_____ Grade: _____
Race/Ethnicity: _____ Religious affiliation: _____

Person completing this form: _____ Today's date: _____
How did you hear of Dr. Jennie Psychology Group? _____
Child's custodian/guardian(s) is/are: _____
Child's home address: _____
City: _____ Province: _____ Postal Code: _____
Home telephone: _____ Teens Phone Number (if one): _____

Best email to reach the family at? _____
Can we contact you by email to let you know about groups or other updates about the clinic?
Yes ☐ No ☐
Would you like to receive appointment confirmations by email? Yes ☐ No ☐

Emergency Contact Name: _____ Relationship to child: _____
City: _____ Phone number: _____

MOTHER's (GAURDIAN) INFORMATION

Mother's name: _____ Date of birth: _____
Home or cell phone: _____ Address: _____
Race/Ethnicity: _____ Religious affiliation: _____
Highest level of education: _____

Marital/relationship status (Check one)
Married: ☐ Living with Partner: ☐ Single: ☐ Separated/Divorced: ☐ Widowed: ☐ Other: ☐

If separated or divorced, do you have a court custody agreement? Yes ☐ No ☐
(If yes, a copy of this document is required at the time this intake form is returned)

Employment status (check all that apply)
Employed: ☐ Retired: ☐ Disabled: ☐ Student: ☐ Homemaker: ☐ Unemployed: ☐

If/when employed, what type of work does mother do? _____
Current employer is: _____
Years on current job: _____ Business Phone: _____

FATHER's (GAURDIAN) INFORMATION

Father's name: _____ Date of birth: _____
Home or cell phone: _____ Address: _____
Race/Ethnicity: _____ Religious affiliation: _____
Highest level of education: _____

Marital/relationship status (Check one)
Married: ☐ Living with Partner: ☐ Single: ☐ Separated/Divorced: ☐ Widowed: ☐ Other: ☐

If separated or divorced, do you have a court custody agreement? Yes ☐ No ☐
(If yes, a copy of this document is required at the time this intake form is returned)

Employment status (check all that apply)
Employed: ☐ Retired: ☐ Disabled: ☐ Student: ☐ Homemaker: ☐ Unemployed: ☐

If/when employed, what type of work does father do? _____
Current employer is: _____
Years on current job: _____ Business Phone: _____

STEP-PARENT'S INFORMATION

Step-parent's name: _____ Date of birth: _____
Home or cell phone: _____ Address: _____
Race/Ethnicity: _____ Religious affiliation: _____
Highest level of education: _____

Marital/relationship status (Check one)
Married: ☐ Living with Partner: ☐ Single: ☐ Separated/Divorced: ☐ Widowed: ☐ Other: ☐

Employment status (check all that apply)
Employed: ☐ Retired: ☐ Disabled: ☐ Student: ☐ Homemaker: ☐ Unemployed: ☐

If/when employed, what type of work does step-parent do? _____
Current employer is: _____
Years on current job: _____ Business Phone: _____

Is it OK to contact stepparent at work? Yes ☐ No ☐ Is it OK to leave a message? Yes ☐ No ☐
Special calling instructions? _____

STEP-PARENT'S INFORMATION

Step-parent's name: _____ Date of birth: _____
Home or cell phone: _____ Address: _____
Race/Ethnicity: _____ Religious affiliation: _____
Highest level of education: _____

Marital/relationship status (Check one)
Married: ☐ Living with Partner: ☐ Single: ☐ Separated/Divorced: ☐ Widowed: ☐ Other: ☐

Employment status (check all that apply)
Employed: ☐ Retired: ☐ Disabled: ☐ Student: ☐ Homemaker: ☐ Unemployed: ☐

If/when employed, what type of work does father do? _____
Current employer is: _____
Years on current job: _____ Business Phone: _____

Is it OK to contact stepparent at work? Yes ☐ No ☐ Is it OK to leave a message? Yes ☐ No ☐
Special calling instructions? _____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems that your child is experiencing:

_____
_____
_____
_____
_____

What has happened to cause you to seek help NOW?

_____
_____
_____
_____
_____

What do you hope to be able to do or achieve as a result of treatment?

_____
_____
_____
_____
_____

What do you consider to be other stresses in your child's life?

_____
_____
_____
_____
_____

HISTORY OF THE PROBLEM

When did your child first start experiencing the problem(s) that brought you to the office today?

_____

How often does the problem occur? _____

How long does it last?_____

Does your child have any thoughts of harming himself/herself? Yes ☐ No ☐

Has your child ever attempted to harm someone else? Yes ☐ No ☐ If yes, please explain:

_____
_____

Does your child have any thoughts of harming someone else? Yes ☐ No ☐

Has your child ever attempted to harm someone else? Yes ☐ No ☐

If yes, please explain:

_____

_____

Has your child received previous intervention/therapy from:

Speech language pathologist: Yes ☐ No ☐
If yes, when and for how long? _____

Behaviour Specialist: Yes ☐ No ☐
If yes, when and for how long? _____

Occupational Therapist: Yes ☐ No ☐
If yes, when and for how long? _____

Has your child ever had other previous therapy/counselling of any kind? Yes ☐ No ☐
If yes, when and for how long? _____
What concerns were addressed in therapy?

_____

_____

Was this experience helpful (please explain)?

_____

_____

Has your child ever been hospitalized for emotional/behavioural problems? Yes ☐ No ☐
If yes, when/where was this:

_____

_____

Has your child been prescribed medications to control emotional/behavioural problems? Yes ☐ No ☐
If yes, please list medications, when prescribed, and by whom:

_____

_____

To your knowledge, has your child experimented with alcohol/drugs? Yes ☐ No ☐
Are you concerned that your child might have or be developing a problem with alcohol or drugs?
Yes ☐ No ☐ If yes, please explain:

_____

_____

_____

Other (including any traumatic experiences the child has endured)?

_____

_____

_____

FAMILY

Has this child ever experienced any parental separations, divorces or deaths? Yes ☐ No ☐
If yes, when? _____
How old was the child at the time? _____
Please describe the circumstances:

_____

_____

If parents are separated or divorced, who has custody of this child?

_____

How often does the non-custodial parents see the child?

_____

Please list the age and sex for each sibling (including deceased and step-siblings):

Age	Sex	Relationship to Child	Living at home?	
			Yes ☐	No ☐
			Yes ☐	No ☐
			Yes ☐	No ☐
			Yes ☐	No ☐
			Yes ☐	No ☐
			Yes ☐	No ☐

Other than any children already indicated above and parents, who else lives in the child's household?

_____

_____

_____

_____

Has anyone in the child's family had any treatment for mental/emotional problems? Yes ☐ No ☐
If yes, please briefly explain (who/when):

_____
_____
_____
_____

Has anyone in the child's family ever attempted or committed suicide? Yes No
If yes, please briefly explain (who/when):

_____
_____
_____

FAMILY HEALTH

Describe father's present health:

_____

Describe mother's present health:

_____

What kinds of stressful events have family members experienced recently?

_____
_____
_____
_____

What kinds of stressful events has your child experienced recently?

_____
_____
_____
_____

Have any family member's been diagnosed with any of the following? (Please check if YES):
If yes, please specify family member's relationship to your child

Cancer	☐	Mental Retardation	☐
Tourette's Syndrome	☐	Anxiety	☐
Diabetes	☐	Seizures/Epilepsy	☐
Heart Disease	☐	Reading Problems	☐
Behaviour Disorder (i.e., ODD)	☐	Speech/Language Problems	☐
Depression	☐	Attention Deficit/Hyperactivity Disorder	☐
Autism Spectrum Disorder	☐	Sleep Difficulties	☐
Schizophrenia	☐	Alcohol/Drug Abuse	☐
Bipolar Disorder	☐	Kidney Disease	☐
Multiple Sclerosis	☐	Migraine Headaches	☐
Alzheimer's Disease	☐	Physical Disability	☐
Other Learning Problem	☐	Stroke	☐
High Blood Pressure	☐	Tics	☐
Other significant health or emotional problem:	☐		

CHILD'S MEDICAL CARE AND HISTORY

Child's Family Physician: _____ Clinic and Phone Number: _____
How often does your child see a doctor? _____ Date of last visit: _____
Pediatrician: _____ Naturopathic Doctor: _____

Does your child have any history of the following (please check all that apply):

Condition	Age	Treated by whom?	Outcome of treatment
Serious Accidents			
Head Injury			
Serious Illness			
Surgery			
Eye, Ear, Nose or Throat Problems			
Seizures			
Allergies			
Loss of consciousness			
Hospitalizations			
Other			

Please list all current medications your child is taking:

_____

_____

Supplements:

_____

_____

Has your child had an eye exam? Yes ☐ No ☐ Date of last visit: _____

Has your child had a hearing test? Yes ☐ No ☐ Date of last visit: _____

CHILD'S EDUCATION

Describe any difficulties your child is having in school:

_____

_____

_____

_____

School (name, city)	Grade	Age	Teacher's Name	School Marks (e.g., A's, B's, C's)

CHILD'S DEVELOPMENT

Pregnancy and Delivery
Was your pregnancy planned? Yes ☐ No ☐
Number of previous pregnancies/miscarriages: _____
Describe any complications that occurred during the pregnancy:
_____
_____
_____

What drugs/medications were used during the pregnancy?
_____
_____

Mother's age at child's birth? _____ Father's age? _____
Length of pregnancy: _____weeks Length of labour: _____
Birth Weight: _____lbs _____ oz
Child's condition at birth:
_____

If a hospital birth, how long was child's stay in hospital?
_____
If your child was adopted, please provide adoption history:
_____
_____
_____

How long was your child breastfed for? _____
At what age did your child first sit up? _____ First crawl? _____ First walk? _____
Spoke first word? _____ Put two words together? _____
Spoke in two to 3-word sentences? _____
Any language delays or difficulties?
_____
_____
_____

At what age was your child fully toilet trained? Daytime: _____ Nighttime: _____
Did your child experience bedwetting after toilet training? Yes ☐ No ☐
If yes, until what age: _____

Did soiling occur after toilet training? Yes ☐ No ☐
If yes, until what age:_____
Describe your child's sleep pattern?

_____

_____

What is your child's typical bedtime? _____ What time does your child typically wake up? _____

Do they have any nighttime waking's? Yes ☐ No ☐
If yes, how many times typically? _____
Any sleep problems?:

_____

_____

_____

Please check and comment if the following behaviours apply to your child:

Anxious	☐	Has frequent temper tantrums	☐
Easily Upset	☐	Has difficulty with changes in routine	☐
Has a low frustration tolerance	☐	Insists on sticking to unusual routines	☐
Engages in repetitive behaviours	☐	Is inflexible in their thinking	☐
Engages in odd behavior	☐	Has own agenda	☐
Has difficulties with attention	☐	Has difficulty making friends/keeping friends	☐
Is impulsive	☐	Often plays alone	☐
Is often on the go or hyperactive	☐	Is resistant to change	☐
Fidgets or moves around in seat	☐	Seems as If they are in their own world	☐

Comments:

_____

_____

_____

As a young child, did your child have problems getting alone with others? Yes ☐ No ☐
If yes, please describe:

_____

_____

_____

Did your child experience any other problems or delays in the first 5 years?

Briefly describe the eating habits of your child (e.g., picky, doesn't eat at the table, night eater, etc.)?

CHILD'S INTERESTS AND ACTIVITIES

Please describe your child's strengths and positive characteristics:

What extracurricular activities (i.e., sports, music, clubs, religious organizations) does your child participate in?

What hobbies or interests does your child have?

Any other information your feel is important and was not asked about?