

**Hardy & Stephens Counseling Associates
Child Intake**

Name of client: _____

Person completing this form: _____

Relationship to client: _____

What is bringing you to counseling at this time?

What areas of your life do you feel are impacted by this problem/issue?

School Home Peers Family Daycare Neighbors

Siblings Parents Relatives Other

Family History:

Family Constellation (who is in your family):

Name	Age	Gender	Relationship	Ethnicity	Location

Current Living Situation (who does your child live with):

What kind of support system does your child have in place?

How would you describe the peer relationships your child has?

What leisure activities does your child enjoy?

How would you describe current family relationships?

What discipline strategies/techniques do you utilize with your child?

Spanking Reasoning Sending to Room Yelling Removing

Privileges Grounding

Effectiveness:

Does your child attend daycare? Y N If so, how many hours per week? _____

Please describe any legal history your child has (eg: acting out, fire starting, cruelty to animals, truancy, etc.)

Developmental & Medical History:

Duration of Pregnancy:

Where there any complications during the pregnancy or delivery? If so, please describe:

Any alcohol/cigarette/drug use prior to or during the pregnancy?

Health at birth:

Please describe your child's disposition as a baby:

Developmental milestones:

Milestone	On Time	Delayed
Speech		
Motor		
Cognitive		

Adaptive		
Social		

Did your child receive any early intervention services?

Does your child have any significant medical concerns or is there any significant family medical history (include allergies, infectious diseases & relevant medical concerns)

Please list all medications your child is currently taking:

Medication	Dosage	Prescribing Physician

Primary Care Physician:

May we contact them?

Clinic:

Address and Phone:

Please describe any sleeping or eating problems your child may have:

Has your child had any toileting problems?

Does your child have a history of a head injury?

Religious Background

What is your religious preference (denomination)?

How important is your faith/religion in your family?

Psychological History

Has your child had any previous counseling or mental health issues?

Please list any previous therapy or assessments (including therapist, date, location, and for what):

Is there any family history of mental health concerns (depression, anxiety, etc.)?

Is there any family history of chemical dependency or treatment?

School Information:

Current School: _____ Grade: _____

Phone Number: _____

Teacher: _____ Social Worker: _____

Previous Schools Attended

School name & location	# of years attended	Phone number

Current achievement (grades, special honors, IEP):

School behavior (include detentions, suspensions):

Activities (sports, music, drama, clubs, etc.):

Special Services/Groups/Support Groups:

Social relationships (with peers, teachers, etc.):

What would you describe as your child's strengths?

What are your child's vulnerabilities?

Is there anything else you think would be important for us to know in helping you/your child?