

# Healing heARTS Counseling, LLC

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## Child Intake Form

### Basic Information

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Other: \_\_\_\_\_

Parent/Legal Guardian Name(s) \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_

Parent/Legal Guardian Phone Number: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

May we leave a message? Yes \_\_\_\_\_ No \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Has your child previously received counseling services? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Counselor/Agency: \_\_\_\_\_

Dates Seen: \_\_\_\_\_ Reason Seen: \_\_\_\_\_

### Family Information

#### Child's Current Household

_____ Natural Parents	_____ Father Only	_____ Father and Step-parent
_____ Adoptive Parents	_____ Mother Only	_____ Mother and Step-parent
_____ Foster Parents	_____ Relatives	_____ Other: _____

#### Primary Household Occupants (anyone currently living with child):

Name	Age	Gender	Relationship to Child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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If parents are divorced, when did divorce occur? \_\_\_\_\_

How old was child when parents divorced? \_\_\_\_\_

How did your child respond to the divorce? \_\_\_\_\_

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Any conflict within the family? \_\_\_\_\_

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### School Information

Name of Child's School: \_\_\_\_\_

Grade Level: \_\_\_\_\_ Teacher Name: \_\_\_\_\_

School Counselor Name: \_\_\_\_\_

Any issues at school? \_\_\_\_\_

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### Medical Information

Primary Doctor: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

Current Diagnosis or medical concerns: \_\_\_\_\_

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List any recent or current medications: \_\_\_\_\_

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### Developmental Information

Was your pregnancy with this child planned: Yes \_\_\_\_\_ No \_\_\_\_\_

Was your pregnancy difficult: Yes \_\_\_\_\_ No \_\_\_\_\_ Please Explain: \_\_\_\_\_

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Was your delivery difficult: Yes \_\_\_\_\_ No \_\_\_\_\_ Please Explain: \_\_\_\_\_

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Was child born premature: Yes \_\_\_\_\_ No \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Has your child had any delays in the following areas:

Physical: \_\_\_\_\_ If Yes, please explain: \_\_\_\_\_

Emotional: \_\_\_\_\_ If Yes, please explain: \_\_\_\_\_

Speech: \_\_\_\_\_ If Yes, please explain: \_\_\_\_\_

Social: \_\_\_\_\_ If Yes, please explain: \_\_\_\_\_

### Presenting Issues

Please describe why you are seeking counseling for this child. \_\_\_\_\_

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Do you have a recent or current CPS case: \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe what the CPS case is about: \_\_\_\_\_

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### Presenting Issues Questionnaire

Only check "yes" if the issue described causes your child significant distress and/or cause problems at school, home, work or in relationships.

Yes\_\_\_ No\_\_\_ Does your child frequently have difficulty getting to sleep or staying asleep?

Yes\_\_\_ No\_\_\_ Does your child have anxiety or worry excessively (more than the average person) about things such as school, work, loved ones?

Yes\_\_\_ No\_\_\_ Does your child have unexpected or "out of the blue" periods of intense fear associated with symptoms such as shakiness, shortness of breath, and/or racing heart?

Yes\_\_\_ No\_\_\_ Does your child experience intense feelings of anxiety or fear that you will be humiliated or embarrassed in front of others?

Yes\_\_\_ No\_\_\_ Is your child bothered by intrusive thoughts or mental images?

Yes\_\_\_ No\_\_\_ Does your child have to perform repetitive behaviors (e.g. hand washing or checking), or mental rituals (e.g. counting, repeating words) to control your anxiety or distress?

Yes\_\_\_ No\_\_\_ Has your child experienced a traumatic event(s) that threatened or actually caused serious physical injury to yourself or others?

Yes\_\_\_ No\_\_\_ As a result, does your child have significant stress such as flashbacks, nightmares, persistent anxiety, or feelings of emotional numbness?

Yes\_\_\_ No\_\_\_ Does your child have times when he/she feels depressed or down most of the day?

Yes\_\_\_ No\_\_\_ Has your child lost interest, motivation, or pleasure in usual activities?

Yes\_\_\_ No\_\_\_ Does your child have chronic difficulties paying attention?

Yes\_\_\_ No\_\_\_ Does your child find it hard to be still?

Yes\_\_\_ No\_\_\_ Has your child ever drank alcohol, smoked cigarettes or taken illegal drugs?

Yes\_\_\_ No\_\_\_ Has your child ever been diagnosed with an eating disorder?

Yes\_\_\_ No\_\_\_ Does your child have difficulty making friends?

Yes\_\_\_ No\_\_\_ Has your child ever harmed themselves physically?

Yes\_\_\_ No\_\_\_ Has your child ever attempted to commit suicide? If yes, please list the most recent date and interventions taken: \_\_\_\_\_

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### **Life Trauam Inventory**

Yes\_\_ No\_\_ Has your child ever been in a serious disaster (for example, an earthquake, hurricane, large fire, explosion)?

Yes\_\_ No\_\_ Has your child ever seen a serious accident (for example, a bad car wreck, someone seriously injured)

Yes\_\_ No\_\_ Has your child ever had a very serious accident?

Yes\_\_ No\_\_ Was a close family member ever sent to jail?

Yes\_\_ No\_\_ Has your child ever been sent to jail?

Yes\_\_ No\_\_ Has your child ever put in foster care or put up for adoption?

Yes\_\_ No\_\_ Has your child ever had a very serious physical or mental illness (for example cancer, heart attack, serious operation, felt like killing yourself, hospitalized for nerve problems)?

Yes\_\_ No\_\_ Is your child sexually active?

Yes\_\_ No\_\_ Has your child ever been pregnant?

Yes\_\_ No\_\_ Has your child ever had an abortion or miscarriage?

Yes\_\_ No\_\_ Has your child ever been separated from you against your will (for example, the loss of custody or visitation or kidnapping)?

Yes\_\_ No\_\_ Has someone close to your child died suddenly or unexpectedly (for example, sudden heart attack, murder or suicide)?

Yes\_\_ No\_\_ Has someone close to your child within the past 12 months died (do NOT include those who died suddenly or unexpectedly)?

Yes\_\_ No\_\_ Has your child witnessed or been a victim of violence between family members (for example, hitting, kicking, slapping, punching, intense yelling, name-calling, etc.)?

Yes\_\_ No\_\_ Has your child been a victim of violence between themselves and a dating partner (for example, hitting, kicking, slapping, punching, intense yelling, name-calling, etc.)?

Yes\_\_ No\_\_ Are there any events we did not include that you would like to mention?

If yes, please explain: \_\_\_\_\_

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*\*Please note: If you answer yes to any of the following 4 questions, and a CPS report has NOT been made, then I am legally obligated to make a CPS report within 24-48 hours.*

Yes\_\_ No\_\_ As far as you are aware, has your child ever been emotionally abused or neglected (for example, being frequently shamed, embarrassed, ignored, or repeatedly told that you were “no good”)?

Yes\_\_ No\_\_ As far as you are aware, has your child ever been physically neglected (for example, not fed, not properly clothed, or left to take care of yourself when you were too young or ill)?

Yes\_\_ No\_\_ As far as you are aware, has your child ever been physically abused (for example, hit, restrained, choked, pushed against wall, etc.)?

Yes\_\_ No\_\_ As far as you are aware, has your child ever been sexually abused?

Is there anything else you would like me to know: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By signing this document below, I agree that the above information is true to the best of my knowledge.

\_\_\_\_\_  
Client Name (Print)

\_\_\_\_\_  
Client or Parent/Legal Guardian Signature

\_\_\_\_\_  
Date