Healing heARTS Counseling, LLC
Bend, Oregon
(541) 668-7613

Child Intake Form

Basic Information

Child Name:_____ Date of Birth:_____

Age:_____ Birth Sex:_____Gender Identity:_____

Sexual Orientation (for teens): _____Race:_____Ethnicity:_____

Parent/Legal Guardian Name(s)_____

Address/City/Zip Code:_____

Parent/Guardian email address:_____

Parent/Guardian Phone Number:_____

May we leave a message? Yes_____No_____

Emergency Contact/Relationship/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

If parents are divorced, when did divorce occur?_____

How old was child when parents divorced?_____

How did your child respond to the divorce?_____

_____

Any conflict within the family?_____

_____

School Information

Name of Child's School:_____

Grade Level:_____Teacher Name:_____

School Counselor Name:_____

Any issues at school?_____

_____

_____

_____

_____

Medical Information

Primary Doctor:_____Date of Last Physical:_____

Current Diagnosis or medical concerns:_____

_____

List any recent or current medications:_____

_____

Developmental Information

Was your pregnancy with this child planned: Yes_____No_____

Was your pregnancy difficult: Yes_____No_____Please Explain:_____

_____

Was your delivery difficult: Yes_____No_____Please Explain:_____

_____

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._____

_____

_____

_____

_____

_____

_____

Do you have a recent or current CPS case:_____Yes_____No

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

_____

_____

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 they 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:_____

_____

Life Trauma 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 harming themselves, hospitalized)?

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?

Yes__ No__ Has someone close to your child within the past 12 months died?

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:_____

_____

**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