DEWANDA GICHEMI, LMSW

Child Intake Form for ages 12 and under

Client's Full Legal Name: _____ Date of Birth: _____

Name of person completing this form: _____ Relationship to client: _____

Contact Information of Parent(s) or Legal Guardian(s):

Client's Primary Residence: _____

- OK to send mail to the above address? Yes No *(please circle one)*

This residence belongs to: _____

Primary phone number: (_____)_____ *(please circle one):* Cell Home Work

Name of Primary Phone Owner: _____ Relationship to client:_____

- OK to leave voice messages? Yes No *(please circle one)* OK to text? Yes No *(please circle one)*

Secondary phone number: (_____)_____ *(please circle one):* Cell Home Work

Name of Secondary phone owner: _____ Relationship to client:_____

- OK to leave voice messages? Yes No *(please circle one)* OK to text? Yes No *(please circle one)*

Email Address: _____

- Ok to communicate through email? Yes No *(please circle one)*

Insurance Information:

Primary Insurance

Name of Insurance: _____

Member/Enrollee ID or Contract#_____ Group #_____

Subscriber *(who holds the policy):* _____ Subscriber's DOB: _____

Subscriber's Address: _____

Secondary Insurance (if applicable)

Name of Insurance: _____

Member/Enrollee ID or Contract#_____ Group #_____

Subscriber *(who holds the policy):* _____ Subscriber's DOB: _____

Subscriber's Address: _____

What is the primary concern to be addressed for the child in counseling? _____

_____

Has the child had any mental/behavioral health treatment in the past? If so, when and where? Please explain:

_____

_____

Personal Information and History:

Please indicate which of the following the child has experienced in the last two years with an X or check:

___ Temper tantrums
___ Lies frequently
___ Angry or easily irritable
___ Talks back/disobeys
___ Difficulty with discipline
___ Parent's separation/divorce
__ Distorted body image
__ Problems with pornography
__ Gender identity issues
__ Cruel to animals
__ Steals or breaks things
__ Eating concerns
___ Feeling hopeless or worthless
___ Suicidal or self-harm thoughts
___ Cutting or self-harm
___ Suicide attempt(s)
___ Inappropriate sexual behavior
___ Extreme risk taking behavior
__ Hates or fears going to school
__ Problems learning in school
__ Poor grades/performing under their ability
__ Problems with family relationships
__ Significant weight gain/loss
___ Crying frequently
___ Has few or no friends
___ Victim of bullying
___ Can't sit still
___ Concentration issues
___ Rapid mood changes
__ Needs things to be perfect
__ Complaints of ache/pain
__ Death in the family
__ Moved (relocated home)
__ Speech concerns

___ Substance exposure: ___ Alcohol ___ Hallucinogens ___ Marijuana/Cannabis __ Unsure
___ Opiates/Opioids ___ Stimulants ___ Sedative/Hypnotics
__ Other: _____

Race and Ethnicity (optional):

___ American Indian or Alaska Native ___ Asian American or Asian ___ African American or Black
___ European American or White ___ Hispanic ___ Pacific Islander
___ Two or More Races ___ Other:_____

Education Status: Grade level: _____

___ Alternative school ___ Home school ___ Private school
___ Public school ___ Not in school/dropped out ___ Unknown
___ Other (please explain) _____

With which gender does the child identify? ___ Female ___ Male ___ Other ___ Unsure
If Other, please specify: _____

Spirituality (optional):

Religious affiliation? Yes No *(circle one)* If yes: _____ ___ Unsure

Legal History:

Any involvement with the legal system, including contact with the police? Yes No *(circle one)*

If yes, please explain the contact between the child and the court system and/or police, and when: _____

_____

_____

Child's Family and/or Supportive Relationships. Please list parent(s) or legal guardian(s) first): ***Living with child?***

Name: _____ Age: _____Relationship: _____ Yes No

Name: _____ Age: _____Relationship: _____ Yes No

Name: _____ Age: _____Relationship: _____ Yes No

Name: _____ Age: _____Relationship: _____ Yes No

Name: _____ Age: _____Relationship: _____ Yes No

Birth and Early Development History:

Is the child adopted? Yes No *(please circle one)* If yes, at what age? _____

Are there any known complications with the pregnancy or birth of the child? Please explain: _____

_____

_____

Are there any known complications or significant problems in the first few years of the child's life? _____

_____

Trauma History: *(please circle one)* If yes, when? Please include any information you feel is important.

Emotional	Yes	No	_____
Neglect	Yes	No	_____
Physical	Yes	No	_____
Sexual	Yes	No	_____
Verbal	Yes	No	_____

Medical History:

Has the child had any medical procedures? Yes No *(please circle one)* If yes, please explain: _____

_____

Please list current medications and what they are taken for:

Name of medication, dose (mg, ml, sublingual, etc.), and frequency	What is it intended for?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please attach another page if necessary.

Any additional information for your treating provider? _____

_____

_____

_____

_____

Thank you for taking time to complete this form.

Client, Parent or Legal Guardian Signature: _____ Date: _____

Signature of Treating Provider: _____