KATHRYN PADRON, LMSW
Counseling and Therapy Services, LLC

Child Intake Form for ages 12 and under

Welcome! Please complete this form so we can better understand your situation.

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

Name of person completing this form and 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 ID or Contract# _____ **Group #**_____

Name of Insurance: _____

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

PO Box for claims *(on the back of the card):* _____

Secondary Insurance ID or Contract# _____ **Group #**_____

Name of Secondary Insurance: _____

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

On the back of the card, is there a PO Box for claims? _____

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

Signature: _____Date: _____

Signature of Treating Provider: _____