Phoenix Behavioral Health Services, LLC

3120 Memorial Drive Two Rivers, WI 54241 (920) 657-1780 FAX (920) 657-1784 www.phoenixbhc.com

CHILD INTAKE FORM

Name _____ **Age** _____ **Birth date** _____

Biological Child _____ Adopted Child _____ Foster Care Child _____ (How long in your home?) _____

Child's School _____ Grade _____ Teacher _____

School Social Worker/Psychologist _____

Ethnicity _____ Do you have any Spiritual variables that may impact treatment? Yes No

PARENTS:

Mother _____ Age _____ Occupation _____

Deceased _____ Age of death _____ Cause of death _____

Father _____ Age _____ Occupation _____

Deceased _____ Age of death _____ Cause of death _____

BROTHERS AND SISTERS: (List name(s) from oldest to youngest)

_____

_____

_____

Who lives in your home? _____

_____

_____

PRESENTING PROBLEM:

State in your own words the nature of the problem you are seeking help for: _____

_____

When did the problem begin? (Approximate dates and circumstances): _____

_____

_____

What do you hope to accomplish through the counseling process?

_____

PHYSICAL HEALTH:
Do you have any concerns about your child's physical health? Please Explain:

_____

_____

Is your child under the care of a physician for treatment of a physical or emotional condition? _____

If yes, please list physician's name, reason for treatment, and date last seen _____

_____

Current Physician _____ Last Examination and Results: _____

_____

Any hospitalizations (where and for what)? _____

_____

DEVELOPMENTAL HISTORY:

Was pregnancy planned? _____

Were there any problems during pregnancy? _____

Were there any complications during labor and delivery? _____

Did caregiver experience any depression during or after pregnancy? _____

Was child breast fed, if so, for how long? _____

At what age did child talk? _____ walk? _____ become toilet-trained? _____

Did caregiver experience any long separation from child (more than 2 weeks?) _____

Check yes or no if any of the following occurred during the first two years of the child's life. If yes, describe and fill in age of occurrence:

	Yes	No	Age of Child
Frequent or lasting painful illness	_____	_____	_____
Major Surgery	_____	_____	_____
Severe Colic lasting more than 1 month	_____	_____	_____
Hospitalization	_____	_____	_____
Physical Abuse	_____	_____	_____
Sexual Abuse	_____	_____	_____
Neglect of physical or emotional care	_____	_____	_____
Verbal abuse or threats of violence	_____	_____	_____
Switches in daycare	_____	_____	_____
Changes in primary caregiver	_____	_____	_____
Main caregiver struggled with parenting skills	_____	_____	_____
Depression or serious physical illness of caregiver	_____	_____	_____

CURRENT CONCERNS: Please circle any area where you think a problem may exist:

Anger/Temper	Anxiety/Nervousness	Stress	Parenting Skills	Guilt
Fears/Phobias	Behavior Problems	Self-Concept	Self-Injury	Recurring Nightmares
Indecision	Relationships	Depression	School Problems	Hopelessness
Irritability	Suicidal Thoughts	Weight Loss/Gain	Concentration	Memory
Mood Swings	Hyperactivity			

Other: _____

What has the school informed you about your child's behavior and or academics?

What are your main concerns regarding your child?

Did or does the child have any of the following behaviors:

	Yes	No	Explain
Temper tantrums			
Unusual fears			
Daredevil behavior			
Sleeping problems			
Eating problems			
Stubborn			
Clumsy			
Shyness			
Impulsive			
Affectionate			
Easily comforted			
Well-Coordinated			
Rocking back & forth			
Blank spells			

Any history of traumatic experiences of any nature?

Any previous testing or counseling (Dates, Place, Findings):

What are your child's strengths?

Does your child make and keep friends easily?

Has your child ever been bullied by a peer?

PARENTING:

Describe your relationship with your child (past & present): _____

_____

_____

How do you feel about being a parent? _____

_____

How do you handle problems with your children? _____

_____

_____

What forms of discipline do you use? _____

_____

_____

To what extent do you rely on your children for support (emotional and/or financial)? _____

_____

_____

Do you have extended family members to whom you are able to turn for emotional support?

_____

_____

RECREATION AND LESURE:

What are your child's hobbies and/or interests? _____

_____

_____

How often does your child involve themselves in their hobbies and interests? _____

_____

_____

How often does your family vacation? _____

How often does your family sit down and eat a meal together? _____

Signature: _____ Date: _____