PHOENIX
Behavioral Health Services LLC
3120 Memorial Drive Two Rivers, WI 54241
Phone (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	Behavioral Problems	Concentration	Depression	Fears/Phobias
Guilt	Hopelessness	Hyperactivity	Indecision	Irritability	Memory
Mood Swings	Parenting Skills	Recurring Nightmares	Relationships	School Problems	Self-Concept
Self-Injury	Stress	Suicidal Thoughts	Weight Loss/Gain		

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? _____

Parent/Guardian Signature: _____

Date: _____