**The Healing Place**

**Child Intake Form**

# I. GENERAL INFORMATION Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Child Name: |  | Date of Birth: |  |
|  |  |  |  |
| Home Address: |  |
|  |  |  |  |
| Languages Spoken: |  | Ethnic/Cultural Identity: |  |
|  |  |
| Gender Identity: | [ ]  Female [ ]  Male [ ]  Non-Binary [ ]  Transsexual [ ]  Other |
|  |  |
| **Parent/Caregiver 1** |
| Name: |  | Date of Birth: |  |
| Phone#: |  | Email Address: |  |
|  |  |  |  |
| **Parent/Caregiver 2** |
| Name: |  | Date of Birth: |  |
| Phone#: |  | Email Address: |  |

**II. REFERRAL INFORMATION**

|  |
| --- |
| Please describe the main reason you are requesting therapy services for your child in the space below:  |
|  |

**III. FAMILY RELATIONSHIPS (Please identify all the people living in the child’s home below)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Name* | *Sex* | *Age* | *Relationship to Child**(i.e. mother, brother, etc.)* | *Please list any concerns or conflicts you have with this person* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Significant Others-** **Please identify significant persons in your child’s life that do NOT live in the home with the child (for example, step-parent, nanny, grandparent, etc.):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Name* | *Sex* | *Age* | *Relationship to You**(i.e. person is my son, partner, etc.)* | *Please list any concerns or conflicts you have with this person* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**IV. MEDICAL HISTORY**

|  |  |
| --- | --- |
| Does your child have any physical disabilities? | [ ]  Yes [ ]  No  |
| If yes, please explain: |  |
|  |  |
| Is your child currently experiencing any major medical problems?  | [ ]  Yes [ ]  No  |
| If yes, please explain: |  |
|  |  |  |  |
| Is your child currently taking any medication(s) regularly? | [ ]  Yes [ ]  No |
| If yes, please list out all the medications using the chart below: |
| Medication Name | Dosage | Purpose | Prescribing Physician |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**V. SOCIAL HISTORY**

|  |  |
| --- | --- |
| How many friends does your child currently have? | [ ]  Many [ ]  Few [ ]  None |
|  |  |  |
| Does you child get along best with: | [ ]  Older Peers [ ]  Same age Peers [ ]  Younger Peers[ ]  Boys [ ]  Girls |
|  |  |
| Does your child participate in social activities outside of school?  | [ ]  Yes [ ]  No  |
| If yes, please list them:  |  |
|  |  |
| Does your family have a religious affiliation | [ ]  Yes [ ]  No  |
| If yes, please describe: |  |
|  |  |
| Is your child currently experiencing any major social conflict? | [ ]  Yes [ ]  No  |
| If yes, please describe: |  |

**VI. EDUCATIONAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Child’s School: |  | School District: |  |
|  |  |  |  |
| Teacher/Counselor’s Name: |  | Current Grade: |  |
|  |  |  |  |
| Has your child ever been tested in the school system for learning disabilities? | [ ]  Yes [ ]  No  |
| If yes, please explain: |  |
|  |  |
| Does your child currently have an Individual Education Plan (IEP) | [ ]  Yes [ ]  No  |
| If yes, please explain: |  |
|  |  |
| What grade(s) does your child most often? | [ ] A’s [ ] B’s [ ] C’s [ ] D’s [ ] F’s  |
| If the child’s grades concern you, please explain: |  |
|  |  |
| Does your child skip classes/school? | [ ]  Yes [ ]  No  |
| If yes, please explain: |  |
|  |  |
| Has your child been expelled or suspended from school? | [ ]  Yes [ ]  No  |
| If yes, please explain: |  |
|  |  |
| Does your child participate in extracurricular activities? | [ ]  Yes [ ]  No  |
| If yes, please explain: |  |
|  |  |
| How do teachers and school personnel describe your child’s behavior and personality in school? |
|  |

**VII. SEXUAL HISTORY**

|  |  |
| --- | --- |
| Has your child started puberty? | [ ]  Yes [ ]  No [ ]  Unknown |
|  |  |
| Is your child actively dating? | [ ]  Yes [ ]  No [ ]  Unknown [ ]  N/A |
| If yes, please describe with whom: |  |
|  |  |
| Is your child currently sexually active? | [ ]  Yes [ ]  No [ ]  Unknown [ ]  N/A |
| If yes, please describe with whom: |  |
|  |  |
| Is your child experiencing any sexual problems? | [ ]  Yes [ ]  No [ ]  Unknown [ ]  N/A |
| If yes, please describe: |  |
|  |  |
| What are your family’s rules, expectations, and or values regarding sex and sexuality? |
|  |

**VIII. PSYCHOLOGICAL HISTORY**

|  |  |
| --- | --- |
| Has your child ever been treated by a psychiatrist before? | [ ]  Yes [ ]  No |
| If yes, please briefly describe diagnosis made and treatment recommendations given: |
|  |
| Is your child still receiving treatment from a psychiatrist? | [ ]  Yes [ ]  No  |
|  |  |
| Has your child ever been treated by a therapist/counselor before? | [ ]  Yes [ ]  No |
| If yes, please briefly describe diagnosis made and treatment recommendations given: |
|  |
| Is your child still receiving treatment from a therapist/counselor? | [ ]  Yes [ ]  No  |
|  |
| Has your child ever experienced what you would consider “abuse”? | [ ]  Yes [ ]  No [ ]  Unknown  |
| If yes, please check all that apply? | [ ]  Physical [ ]  Emotional [ ]  Sexual [ ]  Neglect [ ]  Financial  |
| If yes, please describe any details you are comfortable sharing: |
|  |
| Has your child ever attempted suicide? | [ ]  Yes [ ]  No [ ]  Unknown  |
| If yes, please share the number of times, the circumstances of the attempt, and what medical/psychological treatment was received afterwards (if any): |
|  |
| Has your child ever purposely hurt his/her body in any way? | [ ]  Yes [ ]  No [ ]  Unknown  |
| If yes, please share the number of times, the circumstances of the self-harm, and what medical/psychological treatment was received afterwards (if any) |
|  |
| Is your child currently having any thoughts of hurting himself/herself?  | [ ]  Yes [ ]  No [ ]  Unknown  |
| If yes, please describe any details you are comfortable sharing: |  |
|  |
| Is your child currently having any thoughts of hurting or killing others? | [ ]  Yes [ ]  No [ ]  Unknown  |
| If yes, please describe: |  |
|  |  |
| Has anyone in your family ever been diagnosed with an emotional or psychological disorder?  | [ ]  Yes [ ]  No [ ]  Unknown  |
| If yes, please explain: |  |

**IX. SUBSTANCE ABUSE HISTORY**

|  |  |
| --- | --- |
| Does your child use any of the following substances? | If yes, how frequently do they use? |
| Alcohol | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Cigarettes | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Stimulants / Cocaine | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Hallucinogens/ LSD | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Inhalants/ Poppers | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Marijuana | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Methamphetamines | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Opiates/Heroine | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Pharmaceuticals | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Other | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
|  |  |
| Has the use of any of the above substances been a concern for you? | [ ]  Yes [ ]  No |
| If yes, please describe: |
|  |
| Has your child ever participated in a substance rehabilitation program? | [ ]  Yes [ ]  No |
| If yes, please describe: |
|  |
| Does anyone in your family have a drug or alcohol problem? | [ ]  Yes [ ]  No |
| If yes, please describe: |
|  |

**X. LEGAL HISTORY**

|  |  |
| --- | --- |
| Has your child ever been arrested? | [ ]  Yes [ ]  No |
| If yes, please describe: |  |
|  |
| Has your child ever been sentenced to jail or prison? | [ ]  Yes [ ]  No |
| If yes, please describe: |  |
|  |
| Is your child on any kind of probation or parole? | [ ]  Yes [ ]  No |
| If yes, please describe: |  |
|  |
| Are you or your child currently a party or plaintive to a lawsuit? | [ ]  Yes [ ]  No |
| If yes, please describe: |  |
|  |  |
| Do you or your child have any protective orders for or against you? | [ ]  Yes [ ]  No |
| If yes, please describe: |  |

**XI. MAJOR LIFE EVENTS**

|  |
| --- |
| In the past year, has your family experienced any of the following major life events? |
| Event | If yes, please explain when & how you feel about the event: |
| Marriage | [ ]  Yes [ ]  No |  |
| Death of a Loved One | [ ]  Yes [ ]  No |  |
| Divorce/Separation | [ ]  Yes [ ]  No |  |
| Moved (# of times\_\_\_) | [ ]  Yes [ ]  No |  |
| Domestic Violence | [ ]  Yes [ ]  No |  |
| Birth of a Baby | [ ]  Yes [ ]  No |  |
| Miscarriage/Abortion | [ ]  Yes [ ]  No |  |
| Loss/Change of Employment | [ ]  Yes [ ]  No |  |
| Victim of a Crime | [ ]  Yes [ ]  No |  |
| Witness to a Trauma | [ ]  Yes [ ]  No |  |
| Exposure to Warfare | [ ]  Yes [ ]  No |  |
| Other? | [ ]  Yes [ ]  No |  |
| Is there anything else that was not asked that is important for me to know about you or that you would like me to be aware? |
|  |

# XII. THANK YOU!

Thank you for taking the time to complete this form. You may email the form back to me at sparks@TheHealingPlaceTherapy.com or bring a completed copy with you to our next appointment.

This information is important for me to ensure that I provide the best services to you. I assure you that all your information will remain confidential as part of your treatment record. Only you or your child once they become an adult have access to the record upon request. Please note, that this record along with other documentation about services rendered may be subpoenaed by a court of law. If the record is subpoenaed you will be notified and informed of your rights. If you have any questions or concerns you may contact Steven Parks at 979-464-977 or email TheHealingPlaceTherapy@gmail.com