(405) 343-4244
Client Name: _____ Client ID: _____Date: _____

Child Intake Assessment

Identifying Information:

Name: Last	First	Middle Initial
Date of Birth:	Gender: ☐Male ☐Female	
Insurance Type:	Name and birthdate of primary holder:	
Insurance ID/Number:	Insurance Group Number:	
Age:	Race:	Gender Identity/Sexual Orientation:
Address:		
City:	State:	Zip Code:
Phone:	Emergency Contact:	Phone:
Relationship to Emergency Contact:		
Placement of Child: ☐biological parents ☐mother ☐father ☐adoptive parents ☐foster care ☐other: _____ Custody Arrangement:		

Mother's Name and phone: _____

Father's Name and phone: _____

Guardian's Name and Phone Number: _____

Who is providing information on this child? _____

Medical History:

1. How is the child's overall health now? ☐Excellent ☐Good ☐Fair ☐Poor
2. Please explain any physical problems the child is having now or has had in the last 30 days:

_____

_____

_____

_____

_____

Client Name: _____ Client ID: _____Date: _____

Client's personal physician:

Name:
Address:
Phone Number:
Date of last doctor's visit:
If the child does not have a primary care physician would you like to be referred to one? ☐Yes ☐No
Client's gross motor coordination is: ☐very good ☐fair ☐poor ☐very poor ☐unknown
Client's fine motor coordination is: ☐very good ☐good ☐fair ☐poor ☐very poor ☐unknown
Client's speech is: ☐very good ☐good ☐fair ☐poor ☐very poor ☐unknown
Has the client ever head the following symptoms or diseases: ☐fatigue ☐chest pains ☐constipation ☐skin trouble ☐weight gain ☐headaches ☐diarrhea ☐weight loss ☐kidney trouble ☐fainting ☐weakness ☐stomach trouble ☐dizzy spells ☐night sweats ☐ulcers ☐chills ☐sleeping difficulties ☐loss of appetite ☐other: ☐Measles ☐Polio ☐German Measles ☐Meningitis ☐Mumps ☐Diphtheria ☐Lupus ☐High Blood Pressure ☐Pneumonia ☐Glaucoma ☐Rheumatic Fever ☐Skin Disease ☐Thyroid Disease ☐Heart Disease ☐Bleeding Problems ☐Mononucleosis ☐Blood Clots ☐Anemia ☐Epilepsy/Seizures ☐Bone/joint disease ☐Arthritis ☐Diabetes ☐Food Poisoning ☐Chemical/Drug Poisoning ☐Hepatitis ☐HIV positive ☐Broken bones ☐Concussion ☐Head Injury ☐Dislocations ☐Knocked unconscious ☐Cancer – Type: ☐Hospitalization-Reason:
Has client ever had a positive TB test? ☐ yes ☐ no ☐ unknown If positive was it active? ☐ yes ☐ no ☐ unknown
Does the client smoke? ☐ yes ☐ no ☐ unknown If yes, how much?
Does the client drink? ☐ yes ☐ no ☐ unknown If yes, how much?

Client's current height: ☐ unknown	Height one year ago: ☐ unknown
Client's current weight: ☐ unknown	Weight one year ago: ☐ unknown

Are the child's Immunizations current? ☐yes ☐no If not, what Is needed? _____

Prescriptions the client is currently taking: ☐N/A

Name of Medication	Dosage	Benefit	Prescribing Physician

Client Name: _____ Client ID: _____Date: _____

Allergies: ☐N/A

Medication/Food/Substance	What is the reaction?

Pre-natal Development:

Was the client a planned pregnancy? ☐yes ☐no ☐ unknown Age of mother during pregnancy:

Was the pregnancy full-term? ☐yes ☐no ☐unknown If no, please indicate length of pregnancy:

Were there complications during the pregnancy? ☐yes ☐no ☐unknown If yes, please explain:

Did the mother use drugs during the pregnancy: ☐yes ☐no ☐unknown If yes, please explain:

Infancy and Pre-school years:

What adjectives best describe this child during infancy and toddler years? ☐not known

☐cuddly ☐distant ☐curious ☐demanding ☐loner ☐hyper ☐tense ☐loving ☐angry ☐clingy

Did the child experience any of the following during the first two years? Please check any that apply and explain.

☐not known ☐illness ☐injury ☐trauma ☐prolonged separations

Other information and comments: _____

_____

_____

Developmental Milestones:

At what age did (s)he sit up?	At what age did (s)he crawl?
At what age did (s)he walk?	Speak a single word?
Toilet trained?	Two or more words together?

Family:

Client Name: _____ Client ID: _____Date: _____

The child is primarily being raised by: ☐ Birth parents ☐ Father and stepmother ☐ Foster parents ☐ Mother only ☐ Mother and stepfather ☐ Grandparents ☐Father only ☐ Adoptive parents ☐ Other family members If other family members, please identify: Describe any custody arrangements:

Family of Origin:

Did the primary caregivers argue frequently? ☐yes ☐ no ☐ unknown Did the arguments include verbal abuse? ☐yes ☐ no ☐ unknown Did the arguments include physical violence? ☐yes ☐ no ☐ unknown Did caregivers separate/divorce? ☐ yes ☐ no ☐ unknown If yes, at what age was client? _____ Were there severe financial troubles? ☐ yes ☐ no ☐ unknown Other information:	In the family of origin: Was anyone the victim of physical or sexual abuse (including the client)? ☐ yes ☐ no ☐ unknown Please explain:

Present Situation:

Family member's names (living in household):	Age:	Relationship to client:
Describe the client's relationships with others in the home:		
Does the child have other siblings outside the home? If so, please identify siblings' name; age; relationship- full, half, step; living arrangement:		
How are the client's basic needs (food, clothing, shelter) met?		

Cultural Affiliation:

Client Name: _____ Client ID: _____Date: _____

Are cultural, religious, or spiritual beliefs a significant factor in your family's life? ☐yes ☐no ☐unknown Please explain:
Are you involved in church/religion/faith community? ☐ yes ☐no ☐unknown If yes, what denomination? _____ Describe support received from this community, if any:
Other comments regarding culture/spiritual/belief systems, including any preferences in regards to counseling services:

Education: ☐ Not Attending and Reason:

Name and address of school:	Phone:
Name of primary teacher:	Grade:
Client's grades are: ☐ Mostly A's ☐ A's & B's ☐ Mostly B's ☐ B's & C's ☐ Mostly C's ☐ Mostly D's & F's	
How do you rate your child's English reading/writing skills? ☐ Good ☐ Fair ☐ Poor	
Participates in any special services? ☐ Yes ☐ No Specify:	Previously Identified Learning Disabilities: ☐ N/A ☐ Client has a current IEP Grade IEP was initiated:
Has your child ever failed or been held back for any reason? ☐ Yes – Specify grade _____ ☐ No Had any prolonged absences from school? ☐ Yes ☐ No	Ever been suspended or expelled from any activity? ☐ Yes ☐ No
What is the attitude toward school? ☐ Like it ☐ Dislike it ☐ Excited ☐ Indifferent ☐ Bored ☐ Motivated ☐ Afraid of going to school	How does client interact with his peers? ☐ Positive ☐ Well liked ☐ Negative ☐ Few friends ☐ Does not interact with peers ☐ Unknown
Describe involvement in any extra-curricular activities:	
Other comments about school:	

Leisure Activities:

Client Name: _____ Client ID: _____Date: _____

Identify activities the client enjoys:

Personal Strengths:

Identify what strengths the client has:

Employment: ☐ N/A

Please identify type of work and hours worked per week: Is the client satisfied with their current work situation? ☐ yes ☐ no Please explain:

Mental Health History:

Has this child received mental health counseling or psychiatric treatment in the past? ☐ Yes ☐ No If Yes, where and when: What was the diagnosis?
Has the client ever been hospitalized from mental health or substance abuse problems? ☐ Yes ☐ No If yes, please complete the chart below:

Hospital Name	Admit date	Length of Stay	Reason for stay

Has the client or any of their family members experienced any of the following:

	Child	Mother	Father	Sister	Brother
Depression/Bipolar	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐

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Psychiatric Hospitalization	☐	☐	☐	☐	☐
Suicidal Thoughts	☐	☐	☐	☐	☐
Suicidal Attempts	☐	☐	☐	☐	☐
Alcohol Problems	☐	☐	☐	☐	☐
Drug Problems	☐	☐	☐	☐	☐
Other Mental Health Struggles	☐	☐	☐	☐	☐

Other comments regarding mental health history:

Does the client experience any of the following? (Check all that apply)
☐ anxiousness ☐ hostility/violence ☐ sad/isolated ☐ poor attention skills ☐ moodiness ☐ inappropriate noises ☐ runs away ☐ inability to focus
☐ acts out anger ☐ poor boundaries ☐ baby talk ☐ difficulty getting along w/ others ☐ sleep disturbances ☐ grief and loss issues ☐ interrupts others
☐ taking unnecessary risks ☐ clowns around ☐ defiant to authority

Check any of the following events that have occurred in your life within the last 2 years:
☐ change of residence ☐ death of a friend ☐ loss of employment ☐ divorce ☐ poor health ☐ separation ☐ death of a family member
☐ other trauma/loss (specify below)

Sexual Activity:

☐ No current or past sexual activity ☐ not currently sexually active

☐ history of sexual activity:

☐ history of sexual assault, please explain:

☐ gender identity issues, please explain:

☐ history of sexually transmitted diseases, please explain:

☐ History of pregnancies and/or live births and/or abortions, please explain:

Substance Use:

Please list substances used in the last 30 days:

History of substance abuse:

If past issues with dependency/abuse and no current use, please describe methods to remain clean and sober:

Legal History:

Does the client have a legal or criminal record? ☐ yes ☐ no If yes, please explain:

Does your household have emergency procedures determined for the following situations? If so, what are they?

Tornados?

Fire?