CREATIVE SOLUTIONS
4Kids And Families LLC
A MENTAL HEALTH PRACTICE

Devina Cruickshank Brown, LCSW
Julie Chen, LMHC, CAP

CHILD INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Please list any siblings and their ages: _____

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: (_____)_____ May we leave a message? □Yes □No

Cell/Other Phone: (_____)_____ May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Is your child currently taking any prescription medication?
□ Yes
□ No

Please list: _____

_____

Has your child ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

SCHOOL

1. What is the name of your child's current school?

_____

2. What grade is your child in?

_____

3. Has your child repeated a grade? (if so which grade)

_____

4. Does your child receive any extra help at school? (If so what)

_____

5. Has your child ever been suspended? If so how many times in the current school year?

_____

BIRTH AND DEVELOPMENT

1. Were there any difficulties related to the mother's pregnancy and/or your child's birth?

_____

2. Please indicate when your child met their developmental milestones for sitting, walking and talking.

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child's current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems your child is currently experiencing:

_____

When was their last physical exam: _____

2. How would you rate your child's current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems your child is currently experiencing:

_____

3. How many times per week does your child exercise _____

What types of exercise: _____

4. Please list any difficulties your child experience with appetite or eating patterns.

_____

5. Is your child currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Is your child currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

ALCOHOL/DRUG ABUSE

Past: _____

Current: _____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating-Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

ADDITIONAL INFORMATION

1. Is your family spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

2. What do you consider to be some of your child's and/or family's strengths?

4. What do you consider to be some of your child's challenges?

5. What significant life changes or stressful events has your child and/or family experienced recently:

6. What would you like your child accomplish out of his/her time in therapy?