Family Restoration Counseling Services PLLC
www.familyrestorationcounseling.com
Dallas 214-265-1777 Forney 469-602-5022

Confidential Client (Child) Intake Information

Child's Name:_____ Age:_____ Date of Birth:_____

Gender: ❑Male ❑Female Ethnicity:_____ Currently enrolled in school? ❑Yes ❑No

Name of School (if applicable):_____ Grade:_____

Home Address:
(Street)_____

(City)_____ (State)_____ (Zip Code)_____

Mother/Legal Guardian

Name:_____ Age:_____ Date of Birth:_____

Occupation:_____Employer:_____

Phone number:_____may we contact you using this number? ❑Yes ❑No

Email address:_____ may we contact you using this email? ❑Yes ❑No

Father/Legal Guardian
Name:_____ Age:_____ Date of Birth:_____

Occupation:_____ Employer:_____

Phone number:_____may we contact you using this number ❑Yes ❑No

Email address:_____may we contact you using this email? ❑Yes ❑No

Briefly describe your reasons for bringing your child in for counseling at this time:
_____
_____
_____
_____
_____

Household members: (Please include all individuals currently living in your home)

Name of household member	Age	Relationship

Family Restoration Counseling Services PLLC
www.familyrestorationcounseling.com
Dallas 214-265-1777 Forney 469-602-5022

Family Mental Health History

Has your child previously received any type of mental health services (counseling, psychotherapy, psychiatric services)? ❑ No ❑ Yes, previous therapist/provider_____
When did child receive services?_____

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

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	_____

Medical History

List any significant illnesses, injuries, hospitalizations or special medical needs of child:
_____
_____
_____

From whom or where does your child receive medical care?
Clinic/doctor's name: _____ Phone: _____

If necessary to coordinate treatment, may I contact this health care provider?
❑ N/A ❑ Yes ❑ No

Signature of client/guardian:_____ Date:_____

Is your child currently taking any prescription medication? If yes, please list below:
❑ Yes ❑ No

Name of medication	Dose	Reason for medication

Family Restoration Counseling Services PLLC
www.familyrestorationcounseling.com
Dallas 214-265-1777 Forney 469-602-5022

Social/Emotional History
Please circle all that apply regarding child's social and emotional development:

Likes school	Lack of motivation	Does not complete assignments	
Dislikes school	Organized	Recent change in school work	
Enthusiastic	Unorganized	Fearful	
Anxious	Responsible	Sloppy	Shy/Timid
Difficulty sitting still	Difficulty completing tasks	Motivated	Social/Outgoing
Difficulty making/keeping friends			

Mood Inventory (please check yes or no to the following and explain if applicable)
Does your child make self-deprecatory statements such as: "I'm dumb" or "I'm stupid" or "nobody likes me" or "they are all picking on me"? ❑ yes ❑ no _____
Can your child have fun? ❑ yes ❑ no _____
Does he/she have a problem with anger? ❑ yes ❑ no _____
Is your child often silly, giddy, rude or crude and hyperactive? ❑ yes ❑ no _____
Has there been any sexual acting out? ❑ yes ❑ no _____
Does your child have trouble falling asleep or awaken at night and have trouble going back to sleep? ❑ yes ❑ no_____
Will he/she visit you during the night or ask to sleep in your room? ❑ yes ❑ no _____
Does your child sleepwalk, sleep talk, grind their teeth when sleeping, wet the bed, or have excessive nightmares? ❑ yes ❑ no _____
Has there been recent lying? ❑ yes ❑ no _____
Stealing? ❑ yes ❑ no _____
Cruelty to animals? ❑ yes ❑ no _____
Fire setting or match play? ❑ yes ❑ no _____
Is your child distractible? ❑ yes ❑ no _____
Impulsive? ❑ yes ❑ no _____
Accident-prone? ❑ yes ❑ no _____
Intrusive, (nosey)? ❑ yes ❑ no _____
Is your child a daredevil? ❑ yes ❑ no _____
Is he/she destructive? ❑ yes ❑ no _____
Affectionate? ❑ yes ❑ no _____
Is your child too sensitive to criticism? ❑ yes ❑ no _____
Any phobias or compulsions? ❑ yes ❑ no _____

Child's extra-curricular activities/hobbies/interests:_____
_____
_____
_____
_____

Family Restoration Counseling Services PLLC
www.familyrestorationcounseling.com
Dallas 214-265-1777 Forney 469-602-5022

Developmental History

Was this a planned pregnancy? ❑Yes ❑No
Were there any problems of child's biological mother during this pregnancy (illnesses, infections, etc…)? ❑Yes ❑No ❑Unknown If yes, please describe:_____
Were any medications or substances taken during pregnancy? ❑Yes ❑No ❑Unknown
If yes, list_____
Type of delivery: ❑Vaginal ❑Cesarean section ❑Unknown
Were there any complications during pregnancy/delivery? ❑Yes ❑No ❑Unknown
If yes, please describe:_____
_____
Following the birth of the child, did the child's biological mother experience any mood or behavioral difficulties (eg: postpartum depression, anxiety, excessive fatigue)? ❑Yes ❑No ❑Unknown
If yes, please describe:_____
_____

Infancy/Toddler-**If known, please circle all that applied to the child**:

Colic	Excessive crying
Problems with nursing/taking bottle	Cranky/Irritable
Did not enjoy cuddling	Difficulty switching to solid food
Did not appear to be calmed when held or stroked	Withdrawn/Fearful
Rarely cried	Cried often
Diarrhea	Constipation
Rashes	Difficulty Sleeping

Please check the appropriate box relating to your child's developmental milestones:

	Early	On Time	Late
Sat up	_____	_____	_____
Crawled	_____	_____	_____
Walked	_____	_____	_____
Spoke	_____	_____	_____
Toilet Training	_____	_____	_____

Educational History

Does your child have any problems in the area of reading, writing and/or mathematics? ❑Yes ❑No
If yes, please describe:_____
Does your child have a history of school related behavioral problems? ❑Yes ❑No
If yes, please describe:_____
Does your child receive special education services? ❑Yes ❑No
Does your child receive educational support through a 504 plan? ❑Yes ❑No
If so, for what reason?_____
Does your child have problems with school attendance or truancy? ❑Yes ❑No
Has your child ever repeated a grade? ❑Yes ❑No If yes, what grade?_____

Family Restoration Counseling Services PLLC
www.familyrestorationcounseling.com
Dallas 214-265-1777 Forney 469-602-5022

Legal History

Does your child have any past or present legal issues or concerns? ❑Yes ❑No
If yes, please explain:

_____
_____
_____

If applicable, please initial:

I have provided the most recent custody agreement/court document. If any changes are made while in counseling, I will inform the therapist and provide the most recent court document:_____

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Printed Name Date