Family Restoration
COUNSELING SERVICES

Confidential Child Client Intake

Welcome to Family Restoration Counseling Services! We are honored to be a part of your journey. Please take time to fill out this form to the best of your ability. This form is confidential and will be reviewed by your therapist before your first session.

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

Street Address _____ City _____ State _____ Zip _____

Currently Enrolled In School? ◯ No ◯ Yes, school name & grade described below:

_____

Mother/Legal Guardian

Name _____ Age _____ Date of Birth _____ Occupation _____ Employer _____

Phone Number _____ Email _____ Preferred form of contact _____

Father/Legal Guardian

Name _____ Age _____ Date of Birth _____ Occupation _____ Employer _____

Phone Number _____ Email _____ Preferred form of contact _____

Household Members: Please include all individuals currently living with your child.

Name of Household Member	Age	Relationship to Child

Please briefly describe your reasons for bringing your child in for counseling at this time:

_____

_____

_____

_____

Family Mental Health History

Has your child previously received any type of mental health services (counseling, psychiatric services, etc.)?

○ No ○ Yes _____ _____ _____

If yes, name of clinician | Phone | Date of Services

If necessary to coordinate treatment, may your therapist contact this clinician?

○ No ○ Yes _____ _____

Signature of Parent/Guardian | Date

In the section below, identify any family history of the following conditions. If yes, please indicate the family member's relationship to your child in the space provided (sister, father, grandmother, etc.).

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

Please list any significant illnesses, injuries, hospitalizations, or special medical needs of your child.

_____

_____

_____

From whom/where does your child receive medical care?

_____ _____

Clinic/Doctor's Name Phone

If necessary to coordinate treatment, may your therapist contact this health care provider?

◯ No ◯ Yes ◯ N/A _____ _____

Signature of Parent/Guardian Date

Current Medications

Is your child currently taking any prescription medication?

◯ No ◯ Yes, as listed below:

Name of Medication	Dosage	Reason for Medication

Social/Emotional History

Please indicate all that apply to your child's social and emotional development:

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

Mood Inventory

Please answer "Yes" or "No" to the following questions, and briefly explain if applicable.

My child...

◯No ◯Yes Makes self-deprecatory statements such as "I'm dumb," "I'm stupid," or "no one likes me."

_____

◯No ◯Yes Does not seem to be able to have fun.

_____

◯No ◯Yes Has a problem with anger.

_____

◯No ◯Yes Is often hyperactive, silly, or giddy.

_____

◯No ◯Yes Is often rude or crude.

_____

◯No ◯Yes Has been acting out sexually.

_____

◯No ◯Yes Has trouble falling asleep or staying asleep.

_____

◯No ◯Yes Is uncomfortable sleeping alone/visits parents' bed at night.

_____

◯No ◯Yes Sometimes sleepwalks, sleep talks, grinds their teeth, has excessive nightmares or wets the bed.

_____

◯No ◯Yes Lies frequently/has recently begun lying more often.

_____

◯No ◯Yes Has stolen.

_____

◯No ◯Yes Has shown cruelty/excessively rough play to animals.

_____

Mood Inventory (Continued)

Please answer "Yes" or "No" to the following questions, and briefly explain below if applicable.

My child...

Has set fire to things/is preoccupied with fire.
◯ No ◯ Yes _____

Is easily distractible.
◯ No ◯ Yes _____

Is impulsive.
◯ No ◯ Yes _____

Is accident-prone.
◯ No ◯ Yes _____

Is intrusive/nosey in certain areas.
◯ No ◯ Yes _____

Is overly reckless/is a daredevil.
◯ No ◯ Yes _____

Is destructive.
◯ No ◯ Yes _____

Does not show affection.
◯ No ◯ Yes _____

Is overly sensitive to criticism.
◯ No ◯ Yes _____

Has phobias and/or compulsions.
◯ No ◯ Yes _____

Developmental History

Was this a planned pregnancy? ◯ No ◯ Yes

Were there any problems of the child's biological mother during pregnancy? ◯ No ◯ Yes, described below: ◯ Unknown

Developmental History (Continued)

Were any medications or substances taken during pregnancy? ○ No ○ Yes, described below: ○ Unknown

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Type of delivery: ○ Vaginal ○ C-Section ○ Unknown

Were there any complications during pregnancy or delivery? ○ No ○ Yes, described below: ○ Unknown

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Following the birth of the child, did the child's biological mother experience any mood or behavior difficulties (e.g. postpartum depression, anxiety, excessive fatigue)? ○ No ○ Yes, described below: ○ Unknown

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Please indicate all that apply to your child's development as an **infant** and/or **toddler**:

- ☐ Colic
- ☐ Problems with nursing or taking a bottle
- ☐ Did not enjoy cuddling
- ☐ Did not appear to be calmed when held or stroked
- ☐ Rarely cried
- ☐ Diarrhea
- ☐ Rashes
- ☐ Excessive crying
- ☐ Cranky/Irritable
- ☐ Difficulty switching to solid food
- ☐ Withdrawn/fearful
- ☐ Difficulty sleeping
- ☐ Constipation
- ☐ Other, described below:

Please indicate the nature of your child's developmental milestones:

	Early	On Time	Late	Unknown
Sat up	○	○	○	○
Crawled	○	○	○	○
Walked	○	○	○	○
Spoke	○	○	○	○
Toilet Training	○	○	○	○

Educational History

Does your child have any problems in the area of reading/writing/math? ◯ No ◯ Yes, described below:

_____

_____

Does your child have a history of school related behavioral problems? ◯ No ◯ Yes, described below:

_____

_____

Does your child receive special educational services? ◯ No ◯ Yes

Does your child receive educational support through a 504 plan? ◯ No ◯ Yes, for this reason:

_____

Does your child have problems with school attendance or truancy? ◯ No ◯ Yes, described below:

_____

_____

Has your child ever repeated a grade? ◯ No ◯ Yes: _____Grade (*e.g. 1st, 3rd, etc.*)

Legal History

Does your child have any past or current legal issues or concerns? ◯ No ◯ Yes, described below:

_____

_____

If applicable, please initial:

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

_____ _____ _____

Printed Name of Parent/Legal Guardian Signature Date