



# 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:

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**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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Domestic Violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Eating Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Obsessive Compulsive Behavior	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Schizophrenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Suicide Attempts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

## Medical History

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

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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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Likes school                      | <input type="checkbox"/> Lack of motivation          | <input type="checkbox"/> Does not complete assignments |
| <input type="checkbox"/> Dislikes school                   | <input type="checkbox"/> Organized                   | <input type="checkbox"/> Recent change in school work  |
| <input type="checkbox"/> Enthusiastic                      | <input type="checkbox"/> Unorganized                 | <input type="checkbox"/> Fearful                       |
| <input type="checkbox"/> Anxious                           | <input type="checkbox"/> Responsible                 | <input type="checkbox"/> Sloppy                        |
| <input type="checkbox"/> Difficulty sitting still          | <input type="checkbox"/> Difficulty completing tasks | <input type="checkbox"/> Motivated                     |
| <input type="checkbox"/> Difficulty making/keeping friends | <input type="checkbox"/> Shy/Timid                   | <input type="checkbox"/> 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...

No  Yes 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.  
\_\_\_\_\_

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  - Withdrawn/fearful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

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Does your child have a history of school related behavioral problems?

No

Yes, described below:

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Does your child receive special educational services?

No

Yes

Does your child receive educational support through a 504 plan?

No

Yes, for this reason:

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Does your child have problems with school attendance or truancy?

No

Yes, described below:

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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:

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**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