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# INTAKE FORM FOR PARENT OF CHILD

Completion of this form assists us in working with your child and provides us with a picture of his/her development to date. If there are any questions you don't want to answer, please leave blank. This document is protected within the constraints of the individual treatment and standards governing confidentiality.

Parent/Guardian's Name:_____

Child's Full Name:_____

Address: _____ City, Prov. _____ P.C. _____

E-mail Address: _____

Phone: (H) _____ (C) _____ Birth date: _____

Status of Child (Circle One): Biological Step Adopted Other:_____

Present Marital Status: Single Married Common-law Separated Divorced Widowed

In instances where parents are separated or divorced, we require a copy of the custody agreement. If custody is shared, we also require written consent for counselling from both parents.

Do you have sole legal custody of your child? Yes _____ No _____

Who may we thank for referring you to Fresh Hope? _____

Religious affiliation (if applicable):_____

Please give the following information about who lives with you:

| Name | Relationship to you | Sex | Age |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Do any of your children have an special concerns or issues?_____

_____

Has your child had any previous counselling? Yes _____ No _____ When?_____

What is child's current state of physical health? Poor Fair Good Excellent

Please identify any health problems they have: _____

_____

_____

Check any problems your child has been experiencing or changes in (especially within the last four weeks):

_____ Stomach aches _____ Appetite change _____ Weight gain _____ Weight loss _____ Sight

_____ Allergies _____ Dizziness _____ Diarrhea _____ Constipation _____ Anxiety

_____ Coughing _____ Speech changes _____ Nose bleeds _____ Headaches _____ Fever

_____ Nervousness _____ Nausea _____ Bed wetting _____ Trouble breathing

_____ Can't get to sleep _____ Can't stay asleep _____ Sleeping too much/too little (circle)

Any hospitalizations? Yes _____ No _____ Length of stay & reasons_____

_____

Is your child on any medication? If so, please list and when they began taking them_____

_____

_____

BIRTH AND DEVELOPMENTAL HISTORY

Mother's health during pregnancy. Circle: Any medical complications, alcohol/drug abuse, labour complications or medications taken during pregnancy? Details_____

_____

EDUCATIONAL HISTORY

Has your child ever repeated a grade? If so, which one?_____

How many schools has your child attended to date?_____

Has your child ever required an aid or tutor?_____

Has your child ever had a psycho-educational assessment? Yes _____ No_____ When?_____

What were the findings?_____

_____

SOCIALIZATION

Does your child find it easy or difficult to make friends (Circle one)

Has your child been bullied? Yes _____ No_____ When_____

Has your child been a bully? Yes_____ No_____ When_____

Has your child ever expressed thoughts about harming his/herself? Yes_____ No_____ Details:_____

_____

_____

Is there a history of any of the following in your family (immediate & extended): Circle/mark all that apply:

depression bi-polar alcoholism drug abuse sexual abuse schizophrenia

suicide eating disorder physical abuse psychiatric illness rape

gambling ADHD/ADD untimely death other: _____

OTHER

Is there any other family information that you believe would be helpful for us to know?_____

_____

_____

Date of last physical examination: _____

IMMEDIATE CONCERNS

What brings you in for counselling? _____

_____

_____

_____

_____

When did the problem(s) begin as far as you know?_____

_____

Who is aware of the problem(s)?_____

_____

Are there any significant changes in the home and/or in the child's life that have happened in the last year or two?

_____

_____

_____

What would you like to see happen as a result of coming for help?_____