



The Refuge Center
FOR COUNSELING

Child Intake Form

Demographics

Child's Name: _____ Date: _____ DOB: _____

Child's Primary Address: _____

City: _____ State: _____ Zip: _____ County: _____

School: _____ Grade: _____ Teacher: _____

With whom does the child presently reside? _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Referred by: _____

Therapist Church Physician Agency Friend Internet

Family Information

Father Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

It is customary Refuge practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail at, please provide an alternate mailing address here:

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: Phone or Email (circle one)

Age: _____ Gender: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: Single Married (____ years married) Divorced Widowed (circle one)

Spouse/ Significant Other: _____

Age when first married (if married): _____ Age at birth of child: _____

Has the child's father been previously married? Yes No

Mother Name: _____ **Date:** _____

Address: Same as above _____

City: _____ State: _____ Zip: _____ County: _____

It is customary Refuge practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail at, please provide an alternate mailing address here:

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: Phone or Email (circle one)

Age: _____ Gender: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: Single Married (_____ years married) Divorced Widowed (circle one)

Spouse/ Significant Other: _____

Age when first married (if married): _____ Age at birth of child: _____

Has the child's mother been previously married? Yes No

Custody Arrangements (if applicable)

Primary Residential Parent: _____

Visitation Schedule: _____

Child is with _____ on _____

Child is with _____ on _____

According to your Parenting Plan, who is authorized to make health care related decisions?

Father Mother Joint Other (specify): _____

**Please provide the Refuge Center for Counseling with a copy of your Parenting Plan*

Siblings/ Other Household Members

| Name | Relationship | Age | Gender | School/ Grade |
|-------|--------------|-------|--------|---------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

What kind of relationship does the child have with his/her siblings? Good Fair Poor

What kind of relationship does the mother have with the child? Good Fair Poor

What kind of relationship does the father have with the child? Good Fair Poor

What kind of relationship does the child have with extended family?

Paternal: Good Fair Poor Maternal: Good Fair Poor

How do you communicate love to your child? _____

What are the primary methods of discipline used with your child, and how effective have they been?

Has your child ever experienced any type of abuse? (physical/ sexual/ verbal) Yes No

If yes, please describe: _____

Medical/ Mental Health Information

Is your child currently on any medications? Yes No

If yes, please list all of the medications which your child is currently taking: _____

Medical conditions or illnesses: _____

Accidents or injuries: _____

Hospitalizations: _____

Child's current pediatrician: _____

When was your child's last medical check- up? _____

Has your child experienced any of the following? (check all that apply)

- Surgery Asthma High fever
 Convulsions/ Seizures Eye Problems Meningitis
 Hearing problems Allergies Loss of consciousness
 Other: _____

How would you rate your child's overall health? (circle)

Good 10 9 8 7 6 5 4 3 2 1 Poor

Please indicate disorders which any of the child's blood relatives have had:

- Alcoholism Drug Addiction Anemia Asthma
 Cancer Diabetes Epilepsy Heart Disease

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Suicide Attempt(s) |
| <input type="checkbox"/> Manic Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fears | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> ADHD/ ADD | <input type="checkbox"/> Obsession Compulsion | <input type="checkbox"/> Psychiatric Treatment | |

Briefly describe significant family events which your child has been exposed to: (i.e. divorce, remarriage, death, domestic violence) _____

How does your family celebrate special events (birthdays, accomplishments, etc.)?

Child's Developmental History

Please describe the mother's pregnancy: _____

Were there any problems during the pregnancy of this child? Yes No

If yes, please describe: _____

During pregnancy, did the child's mother:

- | | |
|--|---|
| Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | Use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| Use street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | If yes, please list: _____ |

How was/is the child's *physical health* from 0- 12 years? Good Fair Poor

Explain anything unusual: _____

How was/is the child's *physical development* from 0- 12 years? Good Fair Poor

Explain anything unusual: _____

How was/is the child's *emotional development* from 0- 12 years? Good Fair Poor

Explain anything unusual: _____

Check any of the following which did not occur in a typical developmental time period:

- | | | |
|--|--|--|
| <input type="checkbox"/> Smiled | <input type="checkbox"/> Sat without support | <input type="checkbox"/> Walked alone |
| <input type="checkbox"/> Spoke first word | <input type="checkbox"/> Used 2-3 word sentences | <input type="checkbox"/> Completely weaned |
| <input type="checkbox"/> Started toilet training | <input type="checkbox"/> Completed toilet training | <input type="checkbox"/> Completely dressed self |

Child's Academic History

Does your child enjoy school? Yes No

Does your child have any learning challenges? Yes No

If yes, please describe: _____

Has your child had any special testing or evaluation? Yes No

If yes, please describe: _____

List any special services that your child is currently receiving: (tutoring, speech therapy, etc.)

What grades does your child typically receive in school? Above Average Average Below Average

Has your child ever repeated a grade? If yes, which grade: _____

Is your child involved in any extracurricular activities? (band, sports, etc.) Yes No

If yes, please describe: _____

How many close friends does your child have? _____

How does your child get along with his/her classmates? Good Fair Poor Unsure

How well does your child relate to his/her teachers? Good Fair Poor Unsure

Has your child experienced any of the following problems at school? (check all that apply)

- Incomplete homework
- Behavior problems
- Fighting
- Detention
- Suspension
- Poor attendance
- Exposure to drugs/ alcohol
- Gang influence

Child's Present Psychological Status

Does your child exhibit any of the following negative personal habits? (check all that apply)

- Nail-biting
- Temper tantrums
- Fears
- Thumb sucking
- Bedwetting
- Running away
- Nightmares
- Other: _____

How would you describe the personality of your child? _____

Does your child have any hobbies or other interests? _____

Does your child have any pets? Yes No

If yes, what kind(s) and name(s)? _____

Is there anything currently bothering your child, causing them to worry or be stressed? Yes No

If yes, please explain: _____

Has your child ever experienced any serious personal emotional losses? Yes No

If yes, please explain: _____

How would you rate your child's temper? Short Medium Long

Has your child ever made statements of wanting to hurt themselves or someone else? Yes No

If yes, please explain: _____

Spiritual Inventory

**Please indicate if answers are specific to your family or just your child*

What beliefs or values have been most important in guiding your family life/ your child's life?

What feelings or emotions does your family have about God? Is there any particular image that comes to mind?

Is faith/ spirituality helpful to your family? Very much Somewhat Not at all

From your perspective, is your family's faith/ spirituality helpful to your child?

Very much Somewhat Not at all

Presenting Issues

Why are you currently seeking counseling for your child? _____

Please describe any concerns you have for your child regarding the following:

Behavior _____

Relationships _____

Activities _____

Academics _____

Family Situation _____

Development _____

Habits _____

Gender Confusion _____

Other _____

Additional Information

Has your child previously been in counseling? Yes No

Name of therapist: _____ Date of counseling: _____

Child's response to treatment: _____

Guardian Signature: _____ Date: _____

Guardian Signature: _____ Date: _____