The Refuge Center
FOR COUNSELING

Child Intake Form

Demographics

Child's Name: _____ Date: _____

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 father 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

☐High Blood Pressure ☐Low Blood Pressure ☐Stroke ☐Hepatitis

☐Kidney Disease ☐Venereal Disease ☐Depression ☐Suicide Attempt(s)

☐Manic Depression ☐Anxiety ☐Fears ☐Phobias

☐ADHD/ ADD ☐Obsession Compulsion ☐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? ☐ Yes ☐ No ☐ Unsure Use alcohol? ☐ Yes ☐ No ☐ Unsure

Use street drugs? ☐ Yes ☐ No ☐ 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 <u>not</u> occur in a typical developmental time period:

☐Smiled	☐Sat without support	☐Walked alone
☐Spoke first word	☐Used 2-3 word sentences	☐Completely weaned
☐Started toilet training	☐Completed toilet training	☐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: _____