CENTER FOR
Modern
Family
Dynamics
classes counseling
creativity community

Child Intake Form

Identification Information:

Date: _____

Child's Name: _____ Age: _____ DOB: _____

Child's Primary Address: _____

City: _____ State: _____ Zip: _____

Telephone number: _____

School: _____ Grade: _____ Teacher: _____

*It is customary Center for Modern Family Dynamics 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:*_____

Emergency Contact information:

Name: _____ Relationship: _____

Phone: _____

Guardian's Name (s): _____

Guardian's contact phone number: _____ Email: _____

With whom does the child presently reside? _____

Family Information:

FATHER

Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____

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

Email: _____ Preferred method of contact: **Phone** or **Email** (circle one)

Employer: _____ Occupation: _____

Gross Annual Income (before taxes) $ _____

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

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: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____

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

Email: _____ Preferred method of contact: **Phone** or **Email** (circle one)

Employer: _____ Occupation: _____

Gross Annual Income (before taxes) $ _____

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

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? (circle one)

Father **Mother** **Joint** **Other (specify):** _____

(*) Please provide the Center for Modern Family Dynamics with a copy of your Parenting Plan.

Siblings/ other Household Members:

Name:	Relationship:	Age/ Gender:	School/ Grade:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

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

How do you communicate love to your child?

_____

_____

What are the main 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) If so, please describe:

_____

_____

Additional Information:

Has your child previously been in counseling? Yes No

If yes → Dates and provider: _____

Child's response to treatment: _____

Why are you currently seeking counseling for your child? _____

Who referred you to the Center for Modern Family Dynamics?

_____

Medical/ Mental Health Information:

Medical conditions or illnesses: _____

Accidents or injuries: _____

Hospitalizations: _____

Child's Current Pediatrician: _____

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

Is your child currently on any medications? **Yes** **No**

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

_____

_____

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

Surgery Asthma High fever Convulsions/ Seizures Eye Problems Meningitis

Hearing problems Allergies Loss of consciousness Other

Explain "other" : _____

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

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

Please circle the disorders which any of the child's blood RELATIVES have had:

Alcoholism Drug Addiction Anemia Asthma Cancer Diabetes Hepatitis Epilepsy Heart Disease

High Blood Pressure Low Blood Pressure Stroke Kidney Disease Venereal Disease Psychiatric Treatment

Depression Suicide Attempt(s) Manic Depression Anxiety Fears Phobias ADHD/ ADD

Obsession Compulsion with specific activities

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

_____

_____

How does your child interact with his/her family members? :

_____

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** Use alcohol? **Yes** **No**

Use street drugs? **Yes** **No** 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: _____

Circle any of the following which did NOT occur in a typical developmental time period:

Smiled Sat without support Walked alone Spoke first word

Used two or three word sentences Completely weaned Started toilet training

Completed toilet training Completely dressed him/herself

Child's Academic History:

Does your child enjoy school? **Yes** **No**

Does your child have any learning challenges? If yes, please describe:

_____

Has your child had any special testing or evaluation? If yes, please describe:

_____

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

_____

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

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

Is your child involved in any extra- curricular activities? (band, sports, etc.) 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 do they relate to their teachers? **Good** **Fair** **Poor** **Unsure**

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

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

Child's Present Psychological Status:

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

Nailbiting Temper tantrums Fears Thumbsucking Bedwetting Running away
Nightmares Other

Explain "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? If yes, what kind(s)? _____

Is there anything currently bothering your child, causing them to worry or be stressed? If yes, please explain:

_____

Has your child ever experienced any serious personal, emotional losses? Please describe:

_____

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**

Presenting Issues:

Please describe any of the following concerns which you may have in regards to your child:

Behavior _____

Relationships _____

Activities _____

Academics _____

Family Situation _____

Development _____

Habits _____

Gender Confusion _____

Other _____

Guardian Signature: _____ **Date:** _____