HOPE WORKS

CHILD INTAKE

Form to be completed by parent or guardian

PARENT/GUARDIAN INFORMATION

Name: _____ Date: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

May we call you and leave messages at home? ❑ Yes ❑ No

May we call you and leave messages at work? ❑ Yes ❑ No

May we send mail to you at this address? ❑ Yes ❑ No

Marital Status: ❑ S ❑ M ❑ D ❑ W Date of Current Marriage/Separation: _____ Number of Marriages: _____

Child(ren)'s Name(s): _____ Date of Birth: _____ ❑ M ❑ F

_____ Date of Birth: _____ ❑ M ❑ F

_____ Date of Birth: _____ ❑ M ❑ F

Occupation: _____ Highest Level of Education: _____

Name of other custodial parent: _____ Phone: _____

Do you have consent from the other custodial parent for treatment of said child? ❑ Yes ❑ No If no, this will be required by therapist before counseling may begin.

How much contact per month does the child have with his biological mother/father? _____

Do you believe in God? ❑ Yes ❑ No What is your religious preference? _____

Are you a member of a church? ❑ Yes ❑ No If yes, what church? _____

How much influence does your religion have on your day-to-day activity? ❑ A lot ❑ A moderate amount ❑ A little ❑ None

EMERGENCY CONTACT

Name: _____ Relationship to child: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

Complete all remaining information according to the child coming for treatment.

GENERAL INFORMATION

Name: _____ Date of Birth: _____ ❑ M ❑ F

The child is currently living with: _____

School: _____ Grade: _____

Extracurricular activities/interests: _____

MEDICAL HISTORY

How would you rate your child's current physical health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Is the child currently complaining of any physical problems (e.g. headaches, stomach aches)? ❑ Yes ❑ No

If yes, please explain: _____

Previous hospitalizations for medical reasons Date: _____ Reason: _____

Date: _____ Reason: _____

Please list any medical conditions or disabilities: _____

Please list any learning disabilities: _____

MEDICATION(S) **Over-the-counter or prescription**	**DOSAGE**

COUNSELING AND PSYCHIATRIC HISTORY

Has the child had any previous counseling? ❑ Yes ❑ No If yes, when? _____ For how long? _____

For what reason? _____ Name and location of counselor: _____

Has the child ever been diagnosed with or treated for any type of mental illness? ❑ Yes ❑ No If yes, which type? _____

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness? ❑ Yes ❑ No If yes, which type? _____

PSYCHIATRIC MEDICATION(S)	**DOSAGE**

REASONS FOR SEEKING HELP

What concerns about the child have brought you to counseling today? _____

_____

Where are these concerns causing the most problems for YOU? Please check all that apply:

❑ Home ❑ Work ❑ Marriage ❑ Other: _____

Where are these concerns causing the most problems for the CHILD? Please check all that apply:

❑ Home ❑ School ❑ Friends ❑ Other: _____

When did the present concerns begin to be a problem for the child? _____

What concerns about the child have been identified by others? _____

Please indicate which of the following areas are currently problems the child. Check all that apply:

- ❑ Crying spells
- ❑ Excessive fears or anxieties
- ❑ Difficulty being away from specific family members
- ❑ Hearing voices
- ❑ Getting into trouble at school/play
- ❑ Temper tantrums
- ❑ Difficulty falling asleep/inability to sleep at night
- ❑ Decreased/increased appetite
- ❑ Loss of interest in usual activities
- ❑ Hyperactivity
- ❑ Bullying/picking fights
- ❑ Refusal to respond to authority
- ❑ Nightmares
- ❑ Obsessions/compulsion with specific activities
- ❑ Lack of motivation
- ❑ Lack of self-confidence
- ❑ Difficulty making or keeping friends
- ❑ Other: _____

What do you hope to gain from counseling? _____

_____

How did you hear about HopeWorks Counseling? ❑ Friend ❑ Church ❑ Pastor ❑ Other: _____