Marilyn Stahl, LMFT
MFC #3214
408 Broad St. Suite 10B, Nevada City, CA 95959
Office: 530-265-4016 Fax: 530-470-2958

Biographical Information – Child/Adolescent Intake Form

Name:___________________________________

Current Date:____________________________

Parent's Names:__________________________

____

Birth Date:______________________________

Age:____________________________________

Current Address:_________________________

____

School:_________________________________

Grade:__________________________________

Home Phone:_____________________________

Physician:_______________________________

Cell Phone:______________________________

Insurance:_______________________________

____

Parent's Employment: ____________________

____

____

Source of Referral:________________________

____

SIBLINGS: Name Age Comments

1.____

2.____

3.____

4.____

5.____

List Names and Addresses of any Other Professionals Consulted:

1.____

2.____

3.____

Reason for coming to psychotherapy? Give a brief summary of main problems:________________

____

____

When did you first notice a problem?____

____

PREGNANCY HISTORY:

Age of Mom at conception:_________ Desired sex of child: _____________ Pregnancy planned or unexpected? __________________________Previous perinatal loss:___________________

Describe any physical complications or symptoms during pregnancy:__________________

____

Describe any family events or changes occurring within one year before or after the birth:

____

Give a brief biography of child's birth:____

____

____

INFANCY-TODDLER HISTORY:

Was your child beast fed?__________ Until what age?________________________________

Give a brief description of child's first three years: __________________________________

____

____

In these developmental milestones was your child slow, on task or above average?

Walking:________________________________ Talking:_________________________________

List any additional significant events of childhood: __________________________________

____

____

____

Were any of the following present to a significant degree during the child's first year's of life?

Was not calmed by being held or stroked?____

Did not enjoy cuddling?____

Colic:____________________________ Excessive restlessness?_________________________

Sleeplessness due to restlessness or easy arousal?:___________________________________

Frequent head banging?____

Constantly into everything?____

Excessive number of accidents compared to other children?___________________________

____

TEMPERAMENT:

Describe the child's body function regularity in sleep, hunger, bowel movements:_______

____

Adaptability to change in routine and the ease or difficulty in modifying child's initial response:

____

Response to new situations, new food, people, places, toys, etc.:______________________

____

Mood - amount of pleasant and unpleasant behavior throughout a day:________________

____

Distractibility - degree sounds, people, etc., interfere with child's ongoing activity:______

____

Persistence - duration of activities:____

How would you rate your child's overall level of intelligence compared to other children?

Below Average:____________ Average:_________________ Above Average:___________

SCHOOL:

Academic learning ratings: Good Average Poor

Day Care:____

Nursery school:____

Kindergarten:____

Current grade:____

What grade level is your child currently functioning in the following subjects?

Reading:_____ Spelling: ____ Math: ______Writing: _____ Science: ____ History: _____

Has the child repeated a grade?____________ If so when?____________________________

Present class grade placement:____________ Regular or special class?________________

School:________________________________ Teacher:______________________________

Describe kinds of special assistance your child is currently receiving:_________________

____

Describe briefly any academic school problems:___________________________________

____

Has your child had special testing?____

IF SO, PLEASE INCLUDE OR SEND A COPY OF THE REPORT.

SCHOOL:

Rate child's behavior in school settings: Good Average Poor

Nursery school:____

Kindergarten:____

Current grade:____

Does the teacher describe any of the following as significant classroom problems?

______ Does not sit still in seat ______ Frequently gets up and walks around the class

______ Shouts out without being called on ______ Won't wait for their turn

______ Fiddles at their desk ______ Does not do homework

______ Does not cooperate well in groups ______ Better in a one-to-one relationship

______ Does not respect the rights of others ______ Difficulty paying attention

Briefly describe additional behavior problems in the classroom:_____________________

____

____

What does the teacher consider to be your child's strengths:_______________________

____

____

____

PEER RELATIONSHIPS:

Seeks friendships with peers?__________________ Sought by peers?________________

Mostly friends with others their own age?_________ Younger?__________ Older?______

Describe any problems your child is having with peers:____________________________

____

____

Do you consider your child in social settings to be more a leader or follower?__________

____

MEDICAL HISTORY: (Include age and any complications)

Childhood diseases:____

____

Allergies:____

Surgical Operations:____

MEDICAL HISTORY: (Include age and any complications)

Hospitalizations other than operations:____

____

Head Injuries:____

Convulsions:____

_________________________ with fever________________ without fever_____________

Coma:___________________ Meningitis, encephalitis:______________________________

Persistent high fevers:_____________ Highest fever recorded:_______________________

Eye Problems:_________________________ Ear problems:_________________________

Poisoning:____

Abuse (physical and/or sexual):____

PRESENT MEDICAL STATUS:

Height:_____________ Weight:____________Medications now taking on a regular basis:

____

Present illness(es): ____

____

Is child responsible for their own hygiene?_______________________________________

FAMILY HISTORY OF MOTHER:

Mother's age today:_______________ Number of previous pregnancies:________________

Number of spontaneous abortions:_________ Number of induced abortions:____________

Infertility problems:____

Mother's school experience: Learning Problems:___________________________________

Behavior Problems:____

Medical Problems:____

Have any blood relatives had any problems similar to those your child experiences?_____

____

____

Were your parents physically or sexually abused?__________________________________

____

Do you or other members of your family or your parents have a history of drug and/or alcohol use or abuse?____

FAMILY HISTORY OF FATHER:

Father’s age today:_________ Age at child’s birth:________Infertility Problems:________

Father’s school experience: Learning Problems:_________________________________

Behavior Problems:____

Medical Problems:____

Have any blood relatives had any problems similar to those your child experiences?_____

____

____

Were your parents physically or sexually abused?_________________________________

____

Do you or other members of your family or your parents have a history of drug and/or alcohol use or abuse?____

____

What are your family’s values about nudity in the home?__________________________

____

What are the sleeping arrangements in the home?________________________________

____

What are the words your child uses for private parts of their body and urination and defecation?

____

CHILD INFORMATION:

Child’s identified fears:____

____

____

Child’s weaknesses and strengths:____

____

____

What responsibilities does your child have at home and how do they carry them out? ____

____

How do you discipline your child?____

____

CHILD INFORMATION:

Do you ever criticize your child?____

How? ____

Over what issues?____

What are your major concerns about your child?___________________________________

____

____

What have you attempted to do about this concern?_______________________________

____

What do you hope to see accomplished by your child receiving psychotherapy?_________

____

____

What are you committed to in your life at this time?_______________________________

____

____

Please describe a typical day, including family rules, schedule, problem areas, time for communication (use back of sheet if needed):___________________________________

____

____

____

TRAUMATIC EVENTS:

Has your child experienced any major changes, losses or trauma in the past year such as death, hospitalization, deformity or sickness of a family member or friend; divorce or remarriage of parents; birth of a sibling; parent starting or stopping work; start of a change in school or childcare; family members entering or leaving home on a permanent basis; change in family's financial status; witness to or victim of abuse of any kind; involved in drugs or alcohol; suspension from or failure in school; loss or robbed of important possession; change in where he/she lives or any other factor you feel is relevant to the life of your child?

____

____

____

____

____