SEASONS COUNSELING ORLANDO
INSIGHT • HEALING • TRANSFORMATION

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CONFIDENTIAL INTAKE FORM FOR CHILDREN

Name of person completing form: _____ Date: _____

Child is (circle one): my biological child my adopted child my foster child Other: _____

IDENTIFYING INFORMATION (for child receiving services)

Child's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth ____/____/_____

Ethnicity: [ ] White [ ] Black [ ] Hispanic [ ] Asian [ ] Other Sex: [ ] Male [ ] Female

Email Address: _____

Phone (h): _____ May we contact you here? [ ] Yes [ ] No (Whose #_____)

Phone (c): _____ May we contact you here? [ ] Yes [ ] No (Whose #_____)

Phone (w): _____ May we contact you here? [ ] Yes [ ] No (Whose #_____)

May we leave a message for you? [ ] Yes [ ] No May we text you? [ ] Yes [ ] No

How did you hear about us? [ ] Internet [ ] Physician [ ] Friend [ ] Parent [ ] Other Name: _____

May we thank them for referring you? [ ] Yes [ ] No

FAMILY HISTORY

With whom does the child currently live (names and relationship)? _____

Please provide the following information about the child (as applicable):

Father's Name: _____ Phone #: _____

Father is (circle one): Biological Stepfather Foster Involvement (circle one): A lot Some Minor None

Address: _____

Occupation: _____ D.O.B.: _____

Mother's Name: _____ Phone #: _____

Mother is (circle one): Biological Stepmother Foster Involvement (circle one): A lot Some Minor None

Address: _____

Occupation: _____ D.O.B.: _____

Guardian/Other's Name: _____ Phone #: _____

Relationship to child: _____ Involvement (circle one): A lot Some Minor None

Address: _____

Occupation: _____ D.O.B.: _____

Please provide the following information about the child's brothers and sisters and other children living in the home:

Name (First and Last)	D.O.B.	Relationship (Full, Half, Step, Foster)	Lives with Child?	If no, lives where?
			YES NO	
			YES NO	
			YES NO	
			YES NO	

Does the child or any other family member have a history of alcohol or drug problems? [ ] Yes [ ] No
If yes, please explain: _____
_____

Has the child or any other family member experienced any type of abuse (physical, sexual, domestic or emotional)? [ ] Yes [ ] No If yes, please describe the circumstances: _____
_____

LEGAL HISTORY

Please describe any involvement the child has had with the legal system (arrests, convictions, probation, parole, Etc.): _____
_____

DEVELOPMENTAL HISTORY

Pregnancy and delivery were normal? [ ] Yes [ ] No [ ] I don't know
If no, please explain: _____

Did mother use alcohol or other drugs during pregnancy? [ ] Yes [ ] No [ ] I don't know
If yes, please explain: _____

Please list any medications taken during pregnancy: _____

Did the child reach developmental milestones at a normal age?:

Slept through the night	[ ] Yes [ ] No [ ] I don't know	If no, please explain: _____
Sat alone	[ ] Yes [ ] No [ ] I don't know	If no, please explain: _____
Stood alone	[ ] Yes [ ] No [ ] I don't know	If no, please explain: _____
Walked without help	[ ] Yes [ ] No [ ] I don't know	If no, please explain: _____
Said first words	[ ] Yes [ ] No [ ] I don't know	If no, please explain: _____

MEDICAL HISTORY

Describe the child's current health: [ ] Good [ ] Fair [ ] Poor Date of your last physical exam: ____/____/_____

List any medical conditions, illnesses, treatments, or surgeries: _____

_____

Check any of the following symptoms/sensations that apply presently, or in the recent past:

Headaches	[] Past [] Present	Dizziness	[] Past [] Present	Stomach Trouble	[] Past [] Present
Visual Trouble	[] Past [] Present	Sleep Trouble	[] Past [] Present	Trouble Relaxing	[] Past [] Present
Weakness	[] Past [] Present	Tension	[] Past [] Present	Rapid Heart Rate	[] Past [] Present
Difficulty Breathing	[] Past [] Present	Intestinal Trouble	[] Past [] Present	Hearing Noises	[] Past [] Present
Change in Appetite	[] Past [] Present	Tiredness	[] Past [] Present	Pain	[] Past [] Present
Hearing Voices	[] Past [] Present	Seeing Things	[] Past [] Present	Other	[] Past [] Present

Height: _____ Weight: _____ Weight change in the last 2-3 months: _____

List all current medications the child is taking, including those they seldom use or take only as needed:

Name of Medication(s)	Dosage	Reason for taking

Previous Mental Health Treatment

	YES/NO	WHEN	WHERE	OUTCOME
Counseling?	YES NO			
Psychiatric Treatment?	YES NO			
Self-Injury?	YES NO			
Suicidal Thoughts?	YES NO			
Suicide Attempts?	YES NO			
Danger to Others?	YES NO			
Past/Current Diagnosis?	YES NO			

Is the child presently experiencing suicidal thoughts? [ ] Yes [ ] No

Have any friends or family committed suicide? [ ] Yes [ ] No If yes, when and how? _____

Are you presently experiencing any thoughts of harming another person? [ ] Yes [ ] No

Do we have permission to contact your previous counselor(s)? [ ] Yes [ ] No

PRESENTING PROBLEM

Please check any of the reasons listed below which led you to seek treatment.

[ ] Stress
[ ] Anxiety or worry
[ ] Fatigue/Lack of energy
[ ] Poor appetite or overeating
[ ] Trouble sleeping
[ ] Physical abuse
[ ] Feeling worthless or inferior
[ ] Verbal abuse
[ ] Sexual abuse
[ ] Sexual problems
[ ] Gender Identity
[ ] Anger
[ ] Aggressive behavior
[ ] Bad dreams
[ ] Unwanted memories
[ ] Loss of control
[ ] Impulsive behavior
[ ] Controlling
[ ] Controlled by others
[ ] Obsessive thoughts

[ ] Panic
[ ] Depression
[ ] Family member wants me here
[ ] Other relational problems
[ ] Parenting problems
[ ] Hearing voices
[ ] Emotional abuse
[ ] Eating problems
[ ] Drug use
[ ] Alcohol abuse
[ ] Arguing with parents
[ ] Arguing with brothers/sisters
[ ] Legal Matters
[ ] Trouble making friends
[ ] Getting in trouble at school
[ ] Indecisiveness
[ ] Lack of discipline
[ ] Financial Problems
[ ] Spiritual apathy
[ ] Other: _____

[ ] Crying all the time
[ ] Lack of motivation
[ ] Compulsive behaviors
[ ] Seeing things others don't see
[ ] Poor concentration
[ ] Racing thoughts
[ ] Feeling hopeless
[ ] Guilt
[ ] Death of friend or loved one
[ ] Grief
[ ] Chronic Pain
[ ] Physical disability
[ ] Terminal illness
[ ] Health concerns
[ ] Loneliness
[ ] Fears
[ ] Shyness
[ ] Low self esteem
[ ] Don't like myself
[ ] Other: _____

SCHOOL INFORMATION

What school does the child currently attend? _____

What is the child's teacher's name? _____

What grade is the child in? _____

How many schools has the child attended? _____
In which cities/towns were they located? _____

Does the child have a written IEP (Individualized Education Plan)? [ ] Yes [ ] No
Is the child in special education classes? [ ] Yes [ ] No Type: _____

Is the child experiencing any problems in school?
Academics (grades): [ ] Yes [ ] No
Behavior: [ ] Yes [ ] No
Social (peers or adults): [ ] Yes [ ] No

Please explain any "yes" responses: _____

SOCIAL RELATIONSHIP/FRIENDS

How does the child get along with peers? _____
_____

How does the child get along with adults? _____
_____

Does the child spend more time with (check the closest answer):

[ ] Same age children [ ] Adults
[ ] Older children [ ] Alone
[ ] Younger children

What are your child's hobbies and interests? _____
_____

HOME LIFE

Is there a behavior problem at home? [ ] Yes [ ] No If yes, Please explain: _____
_____
_____

What are your child's strengths? _____
_____

What are the family's strengths? _____
_____

What are your child's weaknesses? _____

_____

What are your family's weaknesses? _____

_____

What kind of discipline is used with the child? _____

Who is the primary disciplinarian? _____

Are there any family circumstances you would like us to be aware of? _____

_____

What goals would you like to see reached as a result of (your child) attending counseling? _____

_____

_____

_____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: _____ Date: _____