JON WINDER, L.P.C.
Child Intake

BASIC INFORMATION:

Client Name:	Today's Date:	Date of Birth

Parent/Guardian Name_____ Relationship to client_____

Address _____

Phone # Home _____ Phone # Work _____ Phone # Cell _____

Social Security # _____ Age_____ Referral Source_____

Email address:_____ Permission is granted to contact by email _____ Yes ____ No

Insurance Company _____ Policy # _____Group #_____
Insured's Name (if other than client) _____ Relationship to Insured_____

1. PRESENTING PROBLEM
Main reason for coming to therapy

_____
Was there a specific event that caused you to seek treatment ? ___Yes ___ No If yes, explain

Check if child is having difficulty with any of the below:

____ Abuse/Trauma ___ Current ___ Past
____ Aggressive Behaviors
____ Addictions
____ Anxiety
____ Appetite-- poor or overeating
____ Avoid interactions with others.
____ Avoid social situations with unfamiliar people.
____ Bed-wetting
____ Bizarre thoughts
____ Chemical Dependency
____ Chronic Tiredness
____ Communication problems
____ Compulsive Behaviors
____ Crying Spells
____ Depression
____ Difficulty Concentrating
____ Easily agitated
____ Easily wound up, hard to calm.
____ Eating Problems
____ Excessive worry
____ Family –marital conflict/poor relations
____ Fatigue or loss of energy
____ Feelings of worthlessness or critical of self
____ Gambling
____ Gender Role/Identity
____ Grieving
____ Hallucinations
____ Headaches
____ Irritable mood

_____ Lack of energy
_____ Little interest or pleasure in activities
_____ Low self esteem
_____ Major temper tantrums or anger rages
_____ Memory Lapses
_____ Moodiness
_____ Nausea/Vomiting
_____ Nervousness
_____ Night terrors or nightmares
_____ Obsessive thinking
_____ Racing thoughts
_____ Inability to concentrate due to emotions
_____ Sadness
_____ Self Injury
_____ Sexually inappropriate behaviors
_____ Sleep disturbance
_____ Social Skills
_____ Substance Abuse
_____ Tense, reactive
_____ Unrealistic Fears
_____ Violent Drawings/Writings
_____ Weight loss/gain

Explain any of above you need to elaborate on.

2. Mental Health History:

History of Trauma (ie: neglect, foster care, frequent moves, chronic pain, parental depression, unmet needs, etc.)

History of Physical, Emotional or Verbal abuse? If Yes, Explain:

History of sexual abuse? If Yes, Explain:

Suicidal and/or Homicidal Thoughts
Is child currently having thoughts of suicide or homicide? ____ yes ____ no Explain:

Has the child ever thought about suicide, made suicidal gestures or attempted suicide?
If Yes, Explain: (Dates, what method, precipitating event, action taken)

Has the child ever thought about homicide, made homicidal gestures or attempted homicide?
If Yes, Explain: (Dates, what method, precipitating event, action taken):

Past Treatment
Has the child been under the care of a psychiatrist? ___ yes ___ no If yes, who, when and for how long?

Is the child being seen in outpatient counseling or have a case manager? If yes, who, when and for how long?
Has the child been hospitalized for psychiatric problems? ____yes ___no If yes, where, when and for what reasons?

Substance Dependence / Abuse History

Alcohol/Drugs Used	Current Use?	Past Use?	Currently a problem? Explain
Caffeine			
Alcohol			
Tobacco			
Ecstasy			
Cocaine/Crack			
Marijuana			

Heroin			
Meth			
PCP/LSD/Mushrooms			
Pain Killers			
Steroids			
Tranquilizers			
Sleeping Pills			
Diet Pills			
Inhalants			
Other:			

History of Mental Illness or Substance Abuse in the Family

RELATIVE	NATURE OF ILLNESS	TREATMENT (IF ANY)

3. MEDICAL HISTORY

Has child been treated by a physician in the last 5 years? __ Yes ___ No If yes, explain:
Has child had any major illness, injuries, operations or hospitalizations? ___ Yes ___ No
If Yes, when and for what reasons:

Current medical complaints:
Current health status:

Current Medications:

Name of Medication	Dosage/frequency	Reason	For how long?	Prescribed By

Medications Taken in the Past and Reason for Stopping:

4. Family History

FAMILY MEMBERS (People living in house, close relatives)

Relationship	Name (mark * if living in home)	Age	Occupation	Residence

What is the child's birth order? ____ of _____ children.
Are biological parents? ____ never married ____ married and living together ____ married but separated
____ divorced: Year of separation or divorce _____

Major family conflicts:

5. EDUCATIONAL HISTORY

What is the highest educational level completed:
School:
Problems with school behavior or academics __Yes __ No If yes, explain
_____

6.LEGAL HISTORY

	Yes	No	Explain any "Yes" answers in Legal History
Pending Charges			
Current Probation			
Current Probation Violations			
Past Incarcerations			
Past Charges			

Other Legal Issues (ie. civil suit, CPS, APS, etc.):

Any other additional information you think would be helpful for me to know?
_____
_____
_____

Thank you for taking time to fill this out.