Positive Kids™
Helping children master social, emotional & cognitive development

Child Intake Form

Child Information:

Child Name: _____ Date: _____
First Middle Last

Form completed by *(if someone other than client)*: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Work: _____ Ext: _____ Cell: _____

Parent/Guardian Email: _____

Reasons for seeking services (check all that apply, CIRCLE PRIMARY REASON):

☐ Anger Management	☐ Anxiety	☐ Coping	☐ Eating Disorder
☐ Fear/Phobias	☐ ODD	☐ Parental Divorce/Sepe	☐ Sleeping Problems
☐ ADHD	☐ Digital Bullying	☐ School Problems	☐ PTSD

☐ Other Mental Health Concerns (specify): _____

Family Information:

Relationship	Name	Age	Living	Living with you
Mother			☐ Yes ☐ No	☐ Yes ☐ No
Father			☐ Yes ☐ No	☐ Yes ☐ No
Child			☐ Yes ☐ No	☐ Yes ☐ No
Child			☐ Yes ☐ No	☐ Yes ☐ No
Child			☐ Yes ☐ No	☐ Yes ☐ No

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Significant Others:

(e.g. brothers, sisters, grandparents, step-relatives. Please specify relationship.)

Relationship	Name	Age	Living	Living with you
----------	----------	----------	☐ Yes ☐ No	☐ Yes ☐ No
----------	----------	----------	☐ Yes ☐ No	☐ Yes ☐ No
----------	----------	----------	☐ Yes ☐ No	☐ Yes ☐ No
----------	----------	----------	☐ Yes ☐ No	☐ Yes ☐ No
----------	----------	----------	☐ Yes ☐ No	☐ Yes ☐ No
----------	----------	----------	☐ Yes ☐ No	☐ Yes ☐ No

Parental Information:

☐ Parents legally married

☐ Have parents ever been divorced

☐ Father Remarried Number of Times: ----------

☐ Have parents ever been separated

☐ Mother Remarried Number of Times: ----------

Any special circumstances (e.g., raised by person other than parents, information about spouse, other children living with client, etc.): ----------

Parental Information:

Are there any unusual or traumatic circumstances that affected child's/client's development?

→ ☐ Yes ☐ No

If yes, please describe: ----------

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Has there been a history of Child Abuse? ☐ Yes ☐ No

If yes, which type(s): ☐ Sexual ☐ Physical ☐ Verbal ☐ Emotional/Psychological

If yes, the abuse was as a: ☐ Victim ☐ Perpetrator

Other childhood issues: ☐ Neglect ☐ Inadequate nutrition ☐ other (please specify): .....

.....

.....

Any further comments about childhood development: .....

.....

.....

Social Relationships:

How does child generally get along with other people (check all that apply)?

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/Argue Often ☐ Follower

☐ Friendly ☐ Leader ☐ Outgoing ☐ Shy/Withdrawn ☐ Submissive

☐ Other (specify): .....

Sexual Orientation: ..... Comments: .....

Sexual Dysfunctions: ☐ Yes ☐ No

If yes, please describe: .....

Any current or history of being a sexual perpetrator? ☐ Yes ☐ No

Spiritual/Religious:

How important to you are spiritual matters? ☐ Not at All ☐ Little ☐ Moderate ☐ Very

Is the family affiliated with a spiritual or religious group? ☐ Yes ☐ No

If yes, please describe: .....

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Legal:

Current Status

Is the child involved in any active legal cases (e.g. traffic, civil, criminal)? ☐ Yes ☐ No

If yes, please describe and indicate the court and hearing/trial dates and charges: ----------

---

Is the child presently on probation or parole? ☐ Yes ☐ No

If yes, please describe: ----------

History

Traffic Violations: ☐ Yes ☐ No
Criminal Involvement: ☐ Yes ☐ No

DWI, DUI: ☐ Yes ☐ No
Civil Involvement: ☐ Yes ☐ No

If you responded yes to any of the above, please fill in the following information:

Charges	Date	Where (City)	Results

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Education:

Years of Education: ---------- Currently enrolled in school? ☐ Yes ☐ No

Leisure/Recreational:

Describe special areas of interest or hobbies (e.g., art, reading, walking, sports, exercising, fishing, etc.):

Activity	How often now?	How often in the past?

Medical/Physical Health:

- ☐ AIDS
- ☐ Abortion
- ☐ Fainting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Eating Problems
- ☐ Sleeping Disorders
- ☐ Headaches
- ☐ Menstrual Problems
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Fatigue
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Vomiting
- ☐ Nose Bleeds
- ☐ Sexual Problems
- ☐ Colds/Coughs
- ☐ Abdominal Pain
- ☐ Bed Wetting
- ☐ Frequent Urination
- ☐ Neurological Disorders
- ☐ Sexual Transmitted Diseases
- ☐ Other (Please explain below)

List any current health concerns: ----------

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Current Medications (please list):

Medication	Dose	Purpose	Side effect

Is child allergic to any drugs? ☐ Yes ☐ No

If yes, list drugs: ----------

Prescribing Psychiatrist/Doctor Contact Information

Name: ---------- Name: ----------

Chemical Use History:

Does child currently use or have a history of chemical use? If yes, briefly describe substance, amount, etc.

Describe how child's/client's use has affected family or friends: ----------

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Reasons for use (check all that apply):

☐ Addicted ☐ Build Confidence ☐ Escape ☐ Self Medication

☐ Socialization ☐ Taste ☐ Other: ----------

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Who or what has helped child in stopping or limiting use? ----------

Does/has someone in child's/client's family (present or past) have or had a problem with drugs or alcohol? ☐ Yes ☐ No

If yes, describe: ----------

Has child had withdrawal symptoms when trying to stop the use of alcohol or drugs in the past?

☐ Yes ☐ No If yes, describe: ----------

Counseling/Prior Treatment History:

Has child ever had counseling before? ☐ Yes ☐ No

If yes, describe when and the experience: ----------

Has child ever had suicidal thoughts or attempted suicide before? ☐ Yes ☐ No

If yes, describe: ----------

Does the client/child feel suicidal at this time? ☐ Yes ☐ No

If yes, describe: ----------

Has child ever been hospitalized in a drug or alcohol treatment program before? ☐ Yes ☐ No

If yes, describe: ----------

Has child ever been hospitalized for psychiatric or mental care before? ☐ Yes ☐ No

If yes, describe: ----------

Behaviors that you notice or your child is reporting (check all that apply):

- ☐ Aggression
- ☐ Dizziness
- ☐ Trembling
- ☐ Antisocial Behavior
- ☐ Panic Attacks
- ☐ Cyber Addiction
- ☐ Sleeping Problems
- ☐ Loneliness
- ☐ Distractibility
- ☐ Thoughts Disorganized
- ☐ Elevated Mood
- ☐ Hopelessness
- ☐ Self-Esteem Issues
- ☐ Hallucinations
- ☐ Judgment Errors
- ☐ Anxiety
- ☐ Phobias/Fears
- ☐ Eating Disorder
- ☐ Body Image Issues
- ☐ Self Injury

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- ☐ Drug Dependence
- ☐ Heart Palpitations
- ☐ Sexual Addiction
- ☐ Fatigue
- ☐ Impulsivity
- ☐ Anger
- ☐ Mood Shifts
- ☐ Worrying
- ☐ Avoiding People
- ☐ Recurring Thoughts
- ☐ Disorientation
- ☐ Suicidal Thoughts
- ☐ Alcohol Dependence
- ☐ Memory Impairment
- ☐ Withdrawing
- ☐ Gambling
- ☐ Irritability
- ☐ Depression
- ☐ Speech Problems
- ☐ Other: _____

Briefly discuss how the above symptoms has led you to seek help for your child at this time and when these behaviors began.

_____

_____

_____

_____

Any additional information that would assist us in this therapeutic process?

_____

_____

_____

_____

For Staff Use:

Therapist's Signature: _____ Date: _____