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Child/Adolescent Initial Evaluation - Birth- Age 5 (Session #1) _____

Parent report: Please complete this confidential intake form completely.

Child's full name: _____

Date of birth: _____ Gender: _____ Race/ethnicity: _____

Child's Address: _____

City/State/Zip: _____ Phone number: _____

Presenting Issues

Adult providing intake information: _____

Please state who referred, or suggested, the idea of an assessment or therapy for your child:

Please state what concerns you have about your child at this time and how long you have been concerned. Please explain in detail, noting your child's emotional and behavioral symptoms, as well as their intensity and frequency: _____

Please list your child's strengths or areas of success: _____

If applicable, please list activities in which your child is actively involved (e.g., music lessons, sport teams, church, etc.): _____

Please state if there is a particular parenting style or philosophy you follow. Please state all methods of redirection and discipline you use with your child, how your child responds to discipline, and if these methods have been successful: _____

Please state what you hope to achieve through counseling: _____

Family Dynamics

If known, please list all disorders and conditions that apply within your child's biological family structure, including those of siblings, parents, grandparents, aunts, uncles, cousins, etc. (e.g., depression, anxiety, substance abuse/addiction, genetic disorders, neurological disorders, emotional/physical/sexual abuse, antisocial/criminal behavior, etc.): _____

Please state if there have been any recent stressors or changes in your environment which may be affecting your child (e.g., divorce or marital problems, death in the family, move to a new home / school / or neighborhood, etc.): _____

Parent Demographics

Please complete the information below *as it pertains to your household* noting step-parents or other caretakers present in your home.

Current caretakers:

Parent #1 _____

Birthday/age _____

Address _____

Home/work/cell phone numbers _____

Email _____

Occupation / Employer _____

Parent #2 _____

Birthday/age _____

Address _____

Home/work/cell phone numbers _____

Email _____

Occupation / Employer _____

If child resides with someone other than biological parents, please explain this arrangement in detail below. If your child is adopted, please provide details of your child's adoption (age at adoption, type of adoption, reasons why adoption was chosen, etc.)

Please list siblings and/or all other individuals living in your child's home, who these individuals are in relation to your child, and each individual's age: _____

Please state your child's legal guardian. If parents are divorced or separated, please provide a copy of the most current court order regarding legal and physical custody: _____

Please list an emergency contact for you and your child with full name and telephone numbers: _____

Please note if you have any particular religious, spiritual, or cultural beliefs that you would like incorporated into the counseling process: _____

Child's Developmental and Medical History

Please list any problems during pregnancy and/or delivery of your child: _____

Please state if your child was exposed to inutero stressors (e.g., mother under emotional stress, mother smoking cigarettes, drinking alcohol or having abused drugs while pregnant, etc.): _____

Please classify your child's early temperament (e.g., easy, quiet, stubborn, shy, difficult, over active, etc.): _____

Please list any physical, cognitive, or social/emotional delays your child has, or has had, (e.g., weaning, walking, talking): _____

Please list any problems your child has had, or currently has, with sleep, eating, or elimination/toileting (e.g., constipation, soiling undergarments): _____

Please list any chronic medical conditions your child currently has, or has had, in the past. If your child is currently in treatment, please state where and with whom: _____

Please detail all of your child's emergency hospital visits, hospitalizations, and surgeries, including child's age, reason, and length of stay: _____

Please list any medications your child *routinely* takes, or has routinely taken in the past, and the reason for this medication: _____

Please list your child's pediatrician with address and telephone number: _____

Please state the last time your child had a physical exam: _____

Child's Daycare / Preschool History

Please provide a timeline of your child's caretaking from birth onward. That is, was your child cared for by a primary parent full-time, or was your child enrolled in daycare or preschool? If so, at what age? If enrolled in daycare/preschool/nanny care, please state how many hours per day and days per week were spent in care: _____

If applicable, please describe how your child is adjusting, or has adjusted, to care away from you while in daycare/preschool/nanny care. This includes child's response to separating from you, reunifying with you, and your child's social/emotional adjustment while in care: _____

Other Providers for Child

Please list *all current providers/agencies* your child is involved with for medical, developmental, and/or mental health purposes. Please list the name of provider, telephone number, and what services you and/or your child are receiving:

Please list any *former providers/agencies* who have seen you and/or your child for medical, developmental, and/or mental health treatment, including the diagnoses your child received, when these services were received, and from whom received: _____

Thank you for completing this form.

Information below to be completed by clinician:

Next Steps

Clinical impressions: _____

Preliminary plan for child and family / recommendations:

Greta Zuck, PhD, LCMHCS, NCC, RPT-S

Date