SWEETWATER
COUNSELING CENTER

Child Intake Form

Please provide the following information about your child:

PATIENT INFORMATION

Patient Last Name: _____ First Name: _____

Marital Status (If Applicable):_____ Date of Birth:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Social Security #:_____ Gender: _____

Employer:_____ Occupation:_____

Employer Address:_____ Length of time with this employer: _____

Please indicate any restrictions on calls: _____

Referring Dr. (if required by insurance):_____

Whom may we thank for referring you? _____

PARENT/GUARDIAN/SPOUSE INFORMATION

Parent/Guardian/Spouse Last Name: _____ First Name:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Date of Birth_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Social Security #:_____ Gender: _____

Employer:_____

EMERGENCY CONTACT INFORMATION

Emergency Contact:_____ Home #:_____ Cell #:_____

PATIENT INSURANCE INFORMATION

Insured Last Name:_____ First Name:_____

Marital Status: _____ Date of Birth:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Insured Social Security #:_____ Sex:_____

Insurance Company:_____ Insurance Billing Address: _____

Insurance Phone: _____

Policy No.:_____ Group No.:_____ Relationship to Insured:_____

Effective Date of Coverage: _____

SECONDARY INURANCE (if applicable)

Insurance Company:_____Insurance Billing Address:_____

Insurance Phone:_____

Policy No:_____Group No:_____Relationship to Insured:_____

Effective Date of Coverage:_____

EMERGENCY CONTACT INFORMATION

Emergency Contact:: _____

Home #: _____ Cell #:_____

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:
What does your child do that you like? What does he /she do that other people like?

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Please provide the following information about your child:

Family History:
The name of the child's biological parents:

Mother:_____ Father:_____

Who has legal guardianship of your child?

Who does your child currently live with?

Names	**Ages**	**Relationship to child**

Who are your child's significant others NOT living with your child?

Names	**Ages**	**Relationship to child**

Please describe any past counseling that either your child or any family member has had.

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____ If yes, Please describe:

Education History:
What school does your child attend?

Address:

Phone:_____ Teachers Name:_____

Current Grade:_____

What does your child's teacher say about him/her?

Other schools attended (including Pre-school)

Has your child ever repeated a grade? If so which one(s)

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

__Fighting	__lack of friends	__drug/alcohol
__Detention	__Suspension	__learning disabilities
__poor attendance	__poor grades	__Gang influence
__incomplete homework		__behavior problems

Medical History:

What is the name of your child's medical doctor?_____

Address: _____ Phone:_____

Date of your child's last medical examination:_____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, Please describe them:

Has your child experienced any of the following medical problems?

__A serious accident	__Hospitalization	__Surgery
__Asthma	__A head injury	__High fever
__Convulsions/seizures	__Eye/ear problems	__Meningitis
__Hearing problems	__Allergies	__Loss of consciousness

Other

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so please describe:

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?