BAYSIDE THERAPY ASSOCIATES CHILD INTAKE FORM

INSTRUCTIONS: PLEASE COMPLETELY FILL OUT BOTH SIDES.

Date: _____ Form Filled Out By: _____
Client Name: _____ Date of Birth: _____ Age: _____
Gender: □Female □Male □_____ Social Security #: _____
Referred By: _____ Primary Care Doctor: _____

Address: _____ City/State/Zip: _____
Home Phone #: _____ Cell #: _____ Work Phone #: _____
OK to leave message? □**YES** □**NO** □**YES** □**NO** □**YES** □**NO**

Parent/Guardian Name: _____Date of Birth: _____ SSI#: _____

Address (if different than above): _____ City/State/Zip: _____

Phone # (If different than above): _____ Cell: _____ Okay To Leave Messages At These Numbers: **Yes** **No**

Mothers Employer: _____ Address: _____ Phone#: _____

Parent/Guardian Name: _____ Date of Birth: _____ SSI #: _____

Address (if different that above): _____ City/State/Zip: _____

Phone # (if different than above): _____ Cell: _____Okay To Leave Messages At These Numbers: **Yes** **No**

Fathers Employer: _____Address: _____ Phone#:_____

Person Responsible for Account: _____

PRIMARY INSURANCE

□ **No Insurance Coverage**

Insurance Co.: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Client ID#: _____
Group/Plan #: _____
Policy Holder Name:_____
Date of Birth:_____ SS #:_____
Relationship to you: _____

SECONDARY INSURANCE

Insurance Co.: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Client ID#: _____
Group/Plan #: _____
Policy Holder Name:_____
Date of Birth:_____ SS #:_____
Relationship to you: _____

FOR OFFICE USE ONLY

Dates of Referral: _____ to _____Date First Consulted: _____
Number of Sessions: _____ Ded.: _____Co-pay/Co-ins: _____

Date	dx code	dx	Counselor Signature

Developmental History: (check all that apply)

Any problems during or after mother's pregnancy?

None	Cigarette Use	Other: _____
Emotional Stress	Domestic Violence	_____
Alcohol Use	Postpartum Depression	_____
Drug Use		

Birth: Normal Delivery Difficult Delivery Cesarean Delivery Complications: _____

_____ Birth Weight: _____lbs. _____ oz.

Infancy: Feeding Problems Sleep Problems Toilet Training Problems Attachment Problems

Delayed Developmental Milestones: (check all that apply to child)

Sitting	Feeding Self	Dressing Self
Rolling Over	Speaking Words	Engaging Peers
Crawling	Speaking Sentences	Tolerating Separation
Standing	Controlling Bladder	Playing
Walking	Controlling Bowels	Riding Bicycle

Childhood Health: (check all that apply to child)

Visual Problems	Ear Infections	Broken Bones
Hearing Problems	Headaches	Asthma
Problems with Coordination	Nausea/Vomiting	Stomach Aches
Physical, Sexual or Emotional Abuse	Lead Poisoning	Allergies to:
	Seizures	_____
Weight Loss/Gain	Soiling/Bedwetting	_____
Speech Problems	Head Injury	

Any chronic or serious health problems: _____

MEDICAL HISTORY

Describe Current Physical Health: □ Good □Fair □Poor

List all medications your child is taking. Include non-prescription drugs and health supplements:

Drug Name:	Date Began:	Purpose:	Dosage:	# Per Day:
1.				
2.				
3.				

Prescribed by: _____

Do you have any allergies to medication? □ Yes □ No If yes, which ones? _____

Check any of the conditions your child has had and the date of onset:					
Condition	**Date**	**Condition**	**Date**	**Condition**	**Date**
ADD/ADHD		Behavior Problems		Learning Disability	
AIDS/HIV		Bipolar Disorder		Low Blood Pressure	
Allergies		Cancer		Migraines	
Anemia		Cutting		Obesity	
Anger Problems		Diabeties		Obsessive/Compulsive	
Anxiety		Eating Disorders		Panic Attacks	
Arthritis		Epilepsy/.Siezure Disorder		Stomach Ulcers	
Asthma		Head Trauma		Skin Problems	
Autism		Heart Disease		Suicide Attempts	
Aspergers		High Blood Pressure		Thyroid Disease	
Depression		Hypoglycemia		Other:	

Check any of the following your child has had in the past three months:

- ☐ Vision Problems
- ☐ Stomach Aches
- ☐ Memory Loss
- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Back Pain
- ☐ Head Injury
- ☐ Weakness in Arms or Legs
- ☐ Constipation
- ☐ Loss of Consciousness
- ☐ Chest Pains or Tightness
- ☐ Hearing Loss
- ☐ Convulsion/Seizures
- ☐ Diarrhea
- ☐ Chronic Pain
- ☐ Fainting
- ☐ Nausea or Vomiting
- ☐ Unusual Bleeding
- ☐ Menstrual Irregularities
- ☐ Headaches
- ☐ Abnormal Growth or Lump

Is there a history of any of the following in your family:											
	GRAND-PARENT	PARENT	SIBLING		GRAND-PARENT	PARENT	SIBLING		GRAND-PARENT	PARENT	SIBLING
ADD/ADHD				Birth Defects				Obsessive/Compulsive			
Alcoholism				Cancer				Panic Disorder			
Alzheimer's Disease/Dementia				Depression				Schizophrenia			
Anger Problems				Diabetes				Seizure Disorder			
Anxiety Disorder				Drug Abuse				Suicide/Homicide			
Aspergers/Autism Disorder				Heart Disease				Thyroid Problem			
Behavior Problems				High Blood Pressure				Violent/Abusive Behavior			
Bipolar Disorder				Mental Retardation				Other:			

Describe Any Hospitalization, Surgeries or Accidents:

Date: _____ Age: _____ Reason: _____

Date: _____ Age: _____ Reason: _____

Date: _____ Age: _____ Reason: _____

LIST OF CHILDREN BEHAVIORS: Please use the following scale to rate your child on each behavior. Indicate how often your child displays that behavior by circling the number which best describes the frequency of each behavior.

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Very Frequently

GROUP A

1	2	3	4	5	Has trouble sleeping
1	2	3	4	5	Has poor appetite
1	2	3	4	5	Seems Sad or Unhappy
1	2	3	4	5	Talks about feeling stupid or worthless
1	2	3	4	5	Loses interest in having fun
1	2	3	4	5	Seems irritable
1	2	3	4	5	Moody
1	2	3	4	5	Plays alone
1	2	3	4	5	Cries easily
1	2	3	4	5	Seems tired

GROUP B

1	2	3	4	5	Complains about physical problems: Like headaches or stomachaches
1	2	3	4	5	Worries
1	2	3	4	5	Lacks confidence in their abilities
1	2	3	4	5	Needs lots of reassurance
1	2	3	4	5	Needs to be perfect
1	2	3	4	5	Seems fearful and anxious
1	2	3	4	5	Seems shy or timid
1	2	3	4	5	Easily embarrassed
1	2	3	4	5	Sensitive to criticism
1	2	3	4	5	Bites fingernails

GROUP C

1	2	3	4	5	Always on the go
1	2	3	4	5	Can't sit still
1	2	3	4	5	Doesn't seem to listen
1	2	3	4	5	Often fails to finish things
1	2	3	4	5	Has poor concentration and attention when comes to schoolwork
1	2	3	4	5	Often fidgets with hand/feet or squirms in seat
1	2	3	4	5	Easily distracted
1	2	3	4	5	Has a hard time playing quietly
1	2	3	4	5	Talks excessively
1	2	3	4	5	Often interrupts or "butts in" to others' games
1	2	3	4	5	Seems disorganized, loses things they need for school
1	2	3	4	5	Takes risks without considering the danger Involved (e.g. running into the street without looking)
1	2	3	4	5	Blurts out answers to questions before they have been completed

GROUP D

1	2	3	4	5	Refuses to follow directions or do chores
1	2	3	4	5	Loses temper
1	2	3	4	5	Argues with parents or teachers
1	2	3	4	5	Blames others for their mistakes
1	2	3	4	5	Swears
1	2	3	4	5	Deliberately does things to annoy other people
1	2	3	4	5	Is Angry or Resentful
1	2	3	4	5	Carries a grudge, seems to have "A chip on their shoulder"
1	2	3	4	5	Touchy, easily annoyed by others

GROUP E

1	2	3	4	5	Steals
1	2	3	4	5	Runs away overnight
1	2	3	4	5	Lies
1	2	3	4	5	Skips school
1	2	3	4	5	Is cruel to animals
1	2	3	4	5	Destroys property
1	2	3	4	5	Gets into fights
1	2	3	4	5	Has been physically cruel to people
1	2	3	4	5	Doesn't seem sorry for hurting others
1	2	3	4	5	Sets fires
1	2	3	4	5	Has broken into a house or car

GROUP F

1	2	3	4	5	Compulsive behavior
1	2	3	4	5	Alcohol or drug use
1	2	3	4	5	Lack of attachment
1	2	3	4	5	Separation problems
1	2	3	4	5	Self-injury acts
1	2	3	4	5	Self-injury threats
1	2	3	4	5	Indecisive
1	2	3	4	5	Immature
1	2	3	4	5	Odd behavior
1	2	3	4	5	Upset with physical appearance
1	2	3	4	5	Sexual behavior
1	2	3	4	5	Distrustful
1	2	3	4	5	Concerns regarding peer influence
1	2	3	4	5	Teased or bullied
1	2	3	4	5	Watches television
1	2	3	4	5	Plays video games
1	2	3	4	5	Internet use

Form Completed By: _____ **Date:** _____

Academic Functioning: (check all that apply)

Learning Problems	Attention Problems	Difficulties with
Authority Conflicts	Underachieving	Schoolwork/Homework

Current School Attending: _____ **Current Grade Level**: _____

Current Teacher Name: _____

Cultural/Spiritual (e.g., ethnicity, religion): _____

Family of Origin

	Present Entire Childhood	Present Part of Childhood	Not Present At All	Current Age
Mother				
Father				
Stepmother				
Stepfather				
Brother(s)				
Sister(s)				
Other (specify)				
Stepbrother(s)				
Stepsister (s)				

Parents Current Marital Status:

Married to each other

Separated for _____ Years

Divorced for _____ Years

Mother Remarried _____ Times

Father Remarried _____Times

Mother Involved with Someone

Father Involved with Someone

Mother Deceased For _____Years

Father Deceased For _____ Years

List other persons living in child's home:		
Name:	Age:	Relationship to Child:

General Information:

Has your child experienced any serious upset? YES NO If yes, what kind: _____
_____

Has your child suffered any significant losses? YES NO If yes, please explain: _____
_____

Does your child have any particular fears? YES NO Comments? _____
_____

Any problems with sleeping? YES NO Comments?_____
_____

Any problems with discipline? YES NO If yes, please describe:_____
_____

How active is your child? _____
_____

List your child's strengths: _____
_____
_____
_____

Please add any information you feel would be helpful: _____
_____
_____

TREATMENT GOALS:

Please list issues to discuss in therapy and specific goals you wish to accomplish:

_____
_____
_____
_____
_____
_____