Santel & Kerr LLC
counseling services

New Client Intake Form (Child/Teen)

Child's Name: _____Age: _____ Birth date_____

Gender/Gender Identity :_____

Client/Child SSN: _____

Parent/Legal Guardian SSN: _____

Cell number (caregiver #1): _____Is it ok to leave a message?_____

Cell number (caregiver #2): _____Is it ok to leave a message?_____

Address: _____

City: _____State: _____Zip code: _____

Email (caregiver #1): _____

Is it ok to email?_____

Email (caregiver #2): _____

Is it ok to email?_____

All and any food/medication/environmental allergies: _____

Is child currently in counseling? (please circle one): _____ Yes _____ No

Counseling History: Please include all psychotherapists, psychiatrists, psychologists, occupational therapists, equine therapists, neurofeedback, or any other types of therapy or treatment you have pursued for your child.

Dates	Therapist	Why	How Helpful (0-10)

Name of child's primary physician and phone number:_____

What medications is your child currently taking?

Medication	Dose	For what

Presenting Problems:

Can you identify any event or experience that preceded these challenges?

When did you first notice these symptoms (approximately?)

Child's Demographics

Child's full legal name: _____

Ethnic identification: _____Year in school _____

Name of School_____Teacher's Name_____

First language spoken: _____

Child's current residence: (please check one)

With biological parents:_____ With Foster Parents _____With Adoptive Parents:____

Other: _____

If Other, please explain: _____

Residential Parents' Demographics:

Parent 1: _____Birth date: _____

Employer: _____

Occupation: _____

Ethnic Identification:_____

Parent 2: _____Birth date: _____

Employer: _____

Occupation: _____

Ethnic Identification: _____

Other parents who child does not reside with:

_____

Who has legal custody (custodial parent) of the child? _____

****custody paperwork stating legal guardianship or custodial parent clearly stating who has the right to consent for treatment must be presented before therapy with a minor child can begin in situations of divorce, dissolution, separation, removal from home, county custody, etc.****

Family/Home Information- Please list everyone who resides in your home full or part time:

Name	Age	Relationship to Child	Full or Part Time Home Member	Gender/Gender Identity

Has the child lived with both parents since birth? _____Yes _____No

If “no”, please list changes chronologically (including all out-of-home placements, hospitalizations, or treatment):

From when:	To when:	Child lived with:	Reason for Move:

If child is not living with both birth parents, please list all reasons:

____Parents separated ____Parents divorced _____Parent/s deceased ___Other
___ Child Adopted _____Foster Care
If other, please explain: _____

If the child has a parent not living with the child, are there visitations? _____Yes _____No

How frequently: _____

Supervised? _____Yes _____ No

Reason: _____

Known or suspected trauma, abuse (physical, sexual, emotional, verbal, mental), neglect, abandonment of the child?:

_____

_____

_____

Is the child currently safe? _____

Does anyone else in the family:

- Have a physical, mental health, or emotional problem? _____ YES _____ NO

If yes, explain:

- Ever received any counseling or taken medications for mental health treatment? ____ YES _____ No

If yes, explain:

- **Have a history of being the perpetrator or victim of domestic violence**? _____ YES _____ NO

If yes, explain:

- **Have a history AT ANY TIME of struggling with drug or alcohol use, misuse, addiction, or treatment?** _____ YES _____ NO

If yes, explain:

Child's Development & Early History:

	YES	NO	Unknown
Was this pregnancy planned?			
Were there any prenatal problems?			
Did the birth mother experience any unusual stress during pregnancy?			
Was the fetus exposed to any drugs or alcohol?			
Were there any problems with delivery?			
Was this child born vaginally?			
Did the child's mother suffer post-partum depression or anxiety?			
Was there any unusual stress in the year after birth?			
Did the infant have feeding problems?			
Did the infant sleep well?			
Was the infant breastfed?			
Was the infant separated from birth mother after birth, even briefly?			
Did your child meet developmental milestones?			
Has your child struggled with bedwetting/soiling (beyond developmentally appropriate?)			
Has your child with daytime toileting accidents (beyond developmentally appropriate?)			
Has your child experienced multiple ear infections?			
Does your child have allergies?			
Has your child ever been hospitalized or to the ER			
Has your child ever had a head injury?			

Would you describe your child in any of these ways during their first years?

	YES	NO	Unknown
Did not enjoy cuddling			
Difficult to comfort			
Restless			
Head Banging			
Reflux			

Not calmed by being held			
Colic			
Excessive irritability			
Constantly into everything			
Listless/Unresponsive			
Overactive			
Adapted easily to change			
Intense feelings			

School

Has your child ever had behavioral, emotional, or academic challenges at school, at any age? If yes, please describe.

Client's Parent/Caregiver #1

Is there anything stressful or unusual about the child's relationship with parent/caregiver #1?

How is the child disciplined by parent #1?

What reasons is the child disciplined by parent #1?

Client's Parent/Caregiver #2

Is there anything stressful or unusual about the child's relationship with parent/caregiver #2?

How is the child disciplined by parent #2?

What reasons is the child disciplined by parent #2?

Describe Your Child:

Typical Behaviors:

How do you respond to these behaviors?

What behaviors distress you the most?

Describe your child's positive qualities.

Describe your child's school behaviors and response to authority.

Describe how this has impacted your:

- Marriage/Relationship (if applicable)
- Family

Describe how this has impacted your:

- Life
- Self

Describe your typical parenting and discipline techniques.

- Which are most effective?
- What are least effective?

Has anyone in your family felt physically threatened?

What are your current biggest worries?

What are your hopes for therapy?

If the child has a birth/adoption/placement history that originated outside of their current home, please explain dates, times, details:

Child Problem Areas/Areas of Concern:

	YES	NO	Unknown
Sadness			
Depression			
Anger/Irritability			
Self-Destructive Behaviors (hair-pulling, biting, hitting, head banging etc)			
Has frequent tantrums			
Guilt			
Fear			
Shame			
Panic/Anxiety			
Loneliness			
Hopelessness			
Helplessness			
Emptiness			

Worthlessness			
Is sluggish or slow moving			
Numbness/Lack of feelings			
Often has physical complaints (headache, stomachache)			
Usually plays alone			
Regression			
Withdrawn			
Gives up easily			
Clinging Behavior			
Gender Identity/Exploration			
Disruptive at home or school			
Substance use/type:			
Absence from school			
Hyperactivity			
Impulsivity			
Sleep changes/difficulties			
Suicide attempts			
Suicidal thoughts/ideas/words			
Does not recognize danger			
Runs away frequently			
Separation anxiety			
Will not play alone			
Problems at mealtime			
Confusion/memory issues			
Zoning-out/blackouts, freezes or collapses			
Epilepsy or seizures			
Cannot dress self			
Cannot feed self			
Is not toilet trained			
Is toilet trained but has accidents:			
Frequent lying			
Stealing			
Hearing voices or “seeing things”			
Body image struggles			
Lack of concentration/focus:			
Adoption			
Significant personality changes			
Medical trauma or surgical history:			
Recent traumatic event			
Changes in relationships with family/friends/school			
“Scary” or negative thoughts, images, etc…			
Recent death/loss or grief			
Social isolation			
Difficulty with attachment			
Hygiene issues			
Somatic/Body Complaints			
Scoliosis or other back injury/pains			
Body repetitive behaviors (skin picking, hair pulling, etc.)			
Digestive issues/concerns (gut, bowel, etc):			
Eating problems, or food issues:			
Self-soothing behaviors:			

"Parents others"			
Chronic Illness, Prognosis:			
Sensory issues			
Other:			

Details about above or other information:

Client Signature: (By signing below I am stating that all above information I know to be true at this time):

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature **Date**

(By signing, you confirm that all legal custodial parents are aware that child is receiving treatment, that it is your responsibility to deliver accurate information to all parties, and any and all changes to custodial agreements will be shared with therapist immediately)

Food Allergies

Our office often uses food as a part of the therapy process. Food items may include fruit snacks, animal crackers, pretzels, candy, or other gummy or cracker. I also have suckers, gum, and mints available.

Even when not used as part of an attachment promoting game, food and snacks are an important part of providing 'felt safety' in the therapy room. Children should never be distracted by feeling hungry. Some children use food to regulate- mostly through the sensory experience (sucking, crunchy, chewy, sweet, etc.) Although we will work to find other ways to regulate, it can be appropriate to take a child's current coping strategies (possibly regulating through food), support those strategies, and eventually develop new or additional strategies. If your child asks for a snack, my answer is almost always "yes." We can talk about this in more detail during the intake process.

If your child has sensitivities or food allergies, please let me know and I will either accommodate them or have you bring in snacks that I keep in the office and reserve for your child only.

_____ Initial here that you have read and understand my food policies.

Referral Information

If you were referred by another professional (physician, school, clergy, therapist, etc.) please fill out the information below:

Name of referring professional: _____

Telephone: _____

May I contact him/her? _____No _____Yes

If you wish us to continue receiving information from and/or providing information to the referring professional regarding your treatment, please complete an "Authorization to Release Information Form."