NORTHVIEW BEHAVIORAL HEALTH SERVICES PLLC
1321West Randol Mill Road, Suite 105.

CHILD INTAKE FORM
(Please complete in Ink)

CHILD

1. Child's Name________________________________Sex______Age_____DOB________
2. Natural Child Yes / No If adopted, at what age______Foster since _____________
3. Parent's Names (include step-parents, foster parents, inc.)

____

____

4. Comments about custody and visitation (if applicable):

____

____

5. Primary reason you are concerned about your child?

____

____

____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

a.
______ Sleep problems
______ Lack of interest in activities
______ Unassertive
______ Fatigue/low energy
______ Concentration problems
______ Appetite/weight changes
______ Withdrawal
______ Morbid thoughts
______ Suicidal thoughts or threats
______ Suicidal plans / attempts
______ Mood swings
______ Depression
______ Changed level of activity
______ Cries easily

b.
______ Forgetful/memory problems
______ Short attention span
______ Aggressive behavior
______ Can't sit still
______ Not interested in peers
______ Picked on / bullied by peers
______ Talks excessively / interrupts
______ Easily distracted
______ Irritable
______ Impulsive
______ Difficulty following rules
______ Problem completing schoolwork

c. _____ Excessive worry / fearfulness
_ Anxiety or panic attacks
_ Social fears, shyness
_ Separation problems
_ Bedwetting / soiling
_ Headaches, stomachaches
_ Odd beliefs / fantasizing

_____ Nightmares
_____ Frequent tantrums
_____ Resistive to change
_____ School refusal
_____ Perfectionism
_____ Odd hand / motor movements
_____ Hallucinations

d. _____ Lying
_ Trouble with the law
_ Running away
_ Truancy, skipping school
_ Hurting others sexually
_ Alcohol / drug use
_ Argumentative / defiant
_ Swears
_ Blames others for mistakes

_____ Stealing
_____ Being destructive
_____ Fire setting
_____ Hurting others / fighting
_____ Acts as if has no fear
_____ Short tempered
_____ Easily annoyed / annoys others
_____ Discipline problem
_____ Angry and resentful

SCHOOL HISTORY

1. Present School:______________________________Grade:_____Teacher:_______________
2. Has child ever repeated any grade? ____
3. Is child in special education services? No_____Yes, what kind? _______________________
4. Please describe academic or other problems your child has had in school

____

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. Pregnancy

Mother used during pregnancy: alcohol______drugs_______cigarettes ______

Delivery: Normal______Breech_______Cesarean_______Transectional_________

Full-term_____________Premature_______if premature, number of weeks ______

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)

____

2. Developmental History

- State approximate age when child did the following:

  Walked alone______Said first word_______Used 2-word phrases ______

- Understood and followed simple directions ______
- Reasonably well toilet trained ______
- Did child cry excessively?______Rarely cried _______

3. Health History of Child

In the first two years, did your child experience:_____Separation from mother,

___Out of home care,____Disruption in bonding,____Depression of mother, ___Abuse,

___Neglect,____Chronic pain,____Chronic Illness, ___Parental Stress

- Child's Doctor: ____
- Date of last physical exam: ____________________
- Vision problems? Yes ______ No______ Hearing problems? Yes ______ No ______
- Dental problems? Yes_____No _____
- Any head injuries or loss of consciousness? Yes ______ No ______
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No______ Yes – describe and give dates __________________

- Is your child currently taking any medications? No_____Yes_____name medications

  ____

- List any medicines previously used for emotional problems: were they helpful? _____

  ____

- Allergies to drugs or medicines? No_____Yes_____(list) ______________________
- Allergies to any foods? No_____Yes_____(list) ______________________________
- Are there any foods that you limit or do not give this child? No_____Yes _____

  (list)____.

- Does anyone in the household smoke? No_____Yes _____
- About how many hours does this child watch TV, videos, etc per day ________
- Are you afraid someone you know may injure/harm this child? No_____Yes _____

  National Domestic Violence Hotline 1-800-799-7233

- Any previous psychological or psychiatric treatment? No______Yes _______

  Whom/where________________________________when_______________

- Any previous testing (school/psychological)? No______Yes ______

  Whom/where_________________________________when_______________

- Do you think your child's use of chemicals is a problem? No______Yes _______

  Type: Alcohol ______ Marijuana ______ Other drugs ______________________

  Comments: ____

Family History:

Chemical use (now & past): No______Yes______Which parent _________________

Type: Alcohol ______ Marijuana ______ Other drugs______________________

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.): ____

____

Has child witnessed domestic violence?__Y,__N, Specify: _________________________

____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused?__Y,__N,__Suspected. Specify: ________________

____

2. Has your child been physically abused?__Y,__N,__Suspected. Specify: _______________

____

3. Has your child been sexually abused?__Y,__N,__Suspected. Specify: ________________

____

4. Other stressors or traumas?____

____

Any additional comments or information that would be helpful to us?

Signature of person completing form / relationship to client:

____Date:________________
Name Relationship