Janet Wilson Counseling, LLC Janet Wilson, M.A., LCPC

Child Intake form

Please fill out this form and bring it to your first session.

Name of Child_______________________________________DOB__________ Age_____

Address_________________________________City___________ State_______Zip_________

School_____________________________________ Grade____ Teacher name_____________

S.S. #______________________Is Child adopted?______ Who has legal custody?__________

Parent Information:

Biological/Adoptive/or Step Mother:

________________________________DOB__________________

Address:________________________________City_________ State_______Zip___________

Home Phone: ( ) May we leave a message? □ Yes □ No
Cell Phone: ( ) May we leave a message? □ Yes □ No

E-mail: ____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Employer_____________________address__________________________phone___________

Biological/Adoptive/or Step Father:

________________________________DOB__________________

Address:______________________________ City_________ State_______Zip___________

Home Phone: ( ) May we leave a message? Yes No text? YN
Cell Phone: ( ) May we leave a message? Yes No text? YN

E-mail: ____ May we email you? Yes No

Employer_____________________address__________________________phone___________

Referred by (if any): ____

HIPAA Agreement was provided (sign here)_____________________________________

Who is your child's current Physician?____

Has the Physician been consulted in regards to your concerns today?___________________

Any current medications? Please list with dosages:

____

____

Please list all of your children, living and deceased, in the order of their birth:

Name________________Age____DOB____Gender____ Grade____________

Name________________Age____DOB____Gender____ Grade____________

Name________________Age____DOB____Gender____ Grade____________

Name________________Age____DOB____Gender____ Grade____________

Name________________Age____DOB____Gender____ Grade____________

Briefly describe your primary concern about your child?

____

____

____

____

____

Briefly describe any history or development of your concern from onset to present?

____

____

____

____

____

How does your child feel about coming to counseling?____________________________________
What are your goals for counseling? ____

____

____

2. How would you rate your child's current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

3. How many hours per week are they on electronics? ____

Social Media______, Game systems_________Phone____________ computer_______

What types sports/music/activities do they participate in?

____

____

4. Are you suspicious of any drug or alcohol use currently?

____

5. Any history of self harm? Suicide thoughts? Attempts?
□ No
□ Yes

If yes, when? __________________Please describe________________________________

____
____
____

6. Is your child currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes Please describe: ____

____
____

7 What has been helpful to remedy your concern? ____________________________________
What has not been effective?____

8. Who has a positive impactful influence on your son/daughter?

9. Who is a contributor to conflict in their life?

10. Do they have a current boyfriend/girlfriend? YN Is this a source of stress? YN

11. What significant life changes or stressful events have they experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
BiPolar	yes/no	
Eating Disorders	yes/no	
Perfectionism	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	

Suicide Attempts yes/no

ADDITIONAL INFORMATION:

Mother's health during pregnancy: unknown, good, some difficulty, many difficulties?
____

Medication/drugs taken during labor: (specify)
____
Length of labor _____hours, Forceps used? ___Yes ___ No Birth weight:___________

Problems/complications during or after delivery?
____

Record CAREFULLY the age at which the child accomplished each of the following:

Sat alone ________ Crawled_________ Stood alone _________Walked alone ____________ Toilet trained_________ Said words _________ Rode bicycle (2-wheeler)________________Used sentences____________________________

Please list any serious illnesses/medical problems that your child has had and give approximate dates:
____
____
List any hospitalizations (*reasons/diagnoses/dates*):____

Have the child's report cards or school conferences indicated any special difficulties?
_____ Class work _____ Behavior _____ Attitude Please describe:______________________
____
____
____

Circle any of the following that definitely describe your child:

Adaptable Affectionate Awkward bedwetting binging/restricting food Clean Considerate Constipation trouble Concentrating Cruel crying spells Doesn't care Day dreams destructive Distractible Easily Led eating problems grief Emotional Fearful Grief health problems headaches ill-tempered Impulsive/acts irritable hair pulling Inconsiderate insecurity Isolation loneliness Inadequate Industrious No ambition lethargic Lacks initiative lying Masturbation nightmares Obedient nervousness Overactive Moody mean to others Problems with parents Pornographic exposure/viewing Panic attacks Quarrelsome Quick tempered Resents authority Runaway Resentful repetitive/'ritualistic behaviors Sassy Reclusive Selfish self -harm self -control stressed out stomach problems Sensitive Sexual Shy Short attention span Spoiled Stubborn School problems social problems stealing suicidal thoughts trouble with law Unmotivated Silliness Temper outbursts Truancy Untidy Untruthful Vain Violent Very unhappy, Won't obey withdrawn worry Work problems

As legal guardian/custodial parent of the child listed above, do you give permission for him/her to engage in counseling/assessment at Janet Wilson Counseling, LLC? Y/N

(For children of divorced parents, please provide a copy of your custody agreement.)

Is the information you have provided on this form true and accurate? ______

Signature______________________________________date_____________

Printed Name___________________________________Relation to child_____________________