Jessica Schild, MSW, LCSW
602-483-6088
Reflect Counseling Services

INTAKE PACKET: CHILDREN & YOUTH

Child/Youth's Name:____DOB:____________

Person completing form:____

Parents' Marital Status: *(Please circle)*:
Married   Separated   Divorced   Never Married   Widowed   Other

Does the child/youth have contact with both parents? Yes   No

If yes, are both parents aware that the child will be starting counseling? Yes   No

If parents are divorced, what is the custody agreement?
____

Child/Youth's primary Residence Address:
____________________________________City:________________________Zip:__________

Second Residence (if applicable) Address:
____________________________________City:________________________Zip:__________

Please list all members living in the primary residence besides the child/youth: Please use the back of form if not enough space.

Name	Age	Gender	Relationship	Relationship Quality

Parent/Guardian Name:____
Relationship to Child/Youth:_________________________
Phone
Number:__________________________Email:_____________________________________

Parent/Guardian Name:____
Relationship to Child/Youth:_____________________________
Phone Number:__________________________Email:_________________________________

It is okay for the therapist to email or text to the phone number above to confirm appointments? Yes No

Is it okay to leave brief messages on the phone numbers listed above? Yes   No

---

Has the child/youth been seen for counseling services before? Yes   No

If so, when, for what, and for how long?
____
____

Briefly describe the outcome of the prior counseling services:
____
____
____

Was the child/youth prescribed psychotropic medication in the past? Yes   No

What was the name of the medication(s)?____________________________________

Please check if any family history of:

___Anxiety
___Depression
___Bipolar Disorder
___Schizophrenia
___Suicide Attempts
___Alcoholism
___Drug Abuse/Dependency
___Neglect
___Sexual abuse
___Physical Abuse
___Emotional Abuse
___Eating Disorders
___Chronic illness
___Panic Attacks
___Learning Disorders (dyslexia, math)
___Communication Disorders
___ADHD
___Violent Temper ("anger issues")
___Hallucinations/Delusions

Please explain any circled answers above and specify if it is on the child's mother's or father's side:
____
____
____

Has the child/youth experienced any of the following?
_____Neglect
_____Physical, sexual or emotional abuse
_____CPS involvement
_____Trauma or assault
_____Violence in the home
_____Death in the family
_____Incarcerated Family members
_____Family members who have been arrested
_____Alcohol or drug abuse (self or family)
_____Serious physical illness (self or family)

Please elaborate on checked items above

MEDICAL HISTORY:

Primary Care Physician:____
Address:_____________________________Phone:____________________
Please describe any past or current medical or physical concerns:____
Please list any allergies:____
Has the child/youth been diagnosed with asthma? Yes No
Please describe any surgeries or hospitalizations:__________________________
Does the child or youth have any of the following?
_____Sensory issues (very particular about textures, wanting to touch a lot of objects)
_____Fine motor issues (handwriting, difficulty with using fingers)
_____Gross motor issues (poor balance, clumsy, difficulty running)
Please list any medications that the child/youth is currently prescribed:____

For Youth Only:
Does the youth smoke cigarettes? Yes No
Does the youth consume alcohol? Yes No
Does the youth take recreational drugs or misuse prescription drugs? Yes No
If yes, please list:____

PRENATAL/BIRTH HISTORY:

Did mother receive prenatal care? Yes No
Did mother use alcohol during pregnancy? Yes No
Did mother use recreational drugs during pregnancy? Yes No
Did mother use alcohol during pregnancy? Yes No
Did mother use prescription medication during pregnancy? Yes No
Did mother experience domestic violence during pregnancy? Yes No
Where there any complications during:
    Pregnancy: Yes No
    Labor: Yes No
    Delivery: Yes No
Was the child/youth born preterm? Yes No
Was the child/youth delivered vaginally? Yes No
Did mother experience post-partum depression or psychosis? Yes No
If answered Yes for any of the above, please describe in more detail____

DEVELOPMENTAL HISTORY:

Please note any delays or concerns with the following developmental milestones:
Crawling____________
Rolling Over____________
Sitting____________
Standing/Walking____________
First Word____________
First sentences____________
Toilet training____________
Other____________

Please check any items below that the child/youth experienced as an infant or toddler:

____Speech/Language Delay
____Hand coordination delay
____ Loss of previous skills
____Overly social with strangers
____Eating non-foods
____Repetitive movements
____Avoidance of eye contact
____Picky eater
____Clingy
____Sensitivity to touch
____Poor attachment to caregiver(s)
____Difficult to comfort

EDUCATIONAL HISTORY:

Current School:____Grade_____
Please list the number of schools the child/youth has attended since kinder:_________
Did the child/youth attend preschool? Yes No
How would you describe the child's/youth's academic performance?
Excellent Good Fair Poor

Please check if the child/youth meets criteria for the following:

____Frequent detentions
____Frequent suspensions
____Frequent calls home
____Expulsion(s)
____IEP
____504 Plan
____Self-contained classroom
____Occupational/speech/physical therapy services
____Tutoring services

SUPPLEMENTAL QUESTIONS:

What are some of the child/youth's strengths?
____
____
____

What areas would you like to see improvements?
____
____
____

What activities/hobbies does the child/youth enjoy?
____
____

Have you noticed any particular event that caused a behavior change in the child/youth?
If yes, please describe

___

___

___

Please check off any items that describe the child/youth's behavior or traits over the past six months.

___Argues, "talks back", defiant
___Bullies/intimidates, teases, provokes others
___Cheats or lies
___Conflicts with caregivers over breaking rules, money, chores, homework, grades
___Lacks respect for authority, insults, dares, provokes, manipulates
___Complains about feeling sick
___Cries easily, feelings are hurt easily
___Temper tantrums
___Procrastinates, appears to waste time
___Difficulty concentrating/paying attention
___Lacks organizations skills, appears unprepared
___Drugs or alcohol use
___Legal issues (on probation, has spent time in Juvenile Hall)
___Failing grades in school
___Fatigue or difficulty sleeping
___Nightmares/panic attacks
___Fighting, hitting, violent, aggressive, hostile, threatens, destructive
___Fire Setting
___Runs away
___Immature, "clowns around", only has younger playmates
___Withdraws, prefers to be alone, isolates
___Low frustration tolerance, irritability
___Mute, refuses to speak
___Nail biting
___Thumb sucking, finger sucking, hair chewing
___Tics: involuntary rapid movements, noises, or word productions
___Rocking or other repetitive movements
___Nervous/anxious
___Shy/timid
___Lack of interest in previous activities
___Self-harming behaviors (biting, hitting self, head banging, scratching self, cutting)
___Recent move, new school, loss of friends
___Preoccupied with sex, public masturbation, or inappropriate sexual behaviors
___Suicidal thoughts or attempts
___Teased, picked on, victimized, bullied
___Avoids school
___Wetting or soiling the bed or clothes
___Uncoordinated/accident prone
___Underactive, slow-moving, lethargic
___Hears voices
___Excessive weight gain or loss
___Odd eating habits
___Questions about gender
___Questions about orientation

If you would like, please expand upon any of the checked items or add other behaviors/traits not listed:

___

___

___