Santa Fe Sage Counseling Center

Child Client Intake

Name:_____ Date:_____

Date of Birth:_____ Age:_____ SS#:_____

Name of person completing form:_____

Emergency Contact Person:_____ Phone:_____

Reasons for coming to counseling at this time:_____
_____
_____

How long have you had this problem?_____

What things have you already tried to do in response to your child's problems?
_____
_____
_____

Are there any situations at home or at school that you think may be affecting your child?
_____
_____
_____

How does your child feel about treatment?
_____
_____

What improvements do you want?

Personal:_____
Family:_____
Social:_____
School:_____

Is your child currently receiving other counseling services? _____Yes _____ No
If yes, please describe_____

Has your child had any previous counseling or psychiatric care? _____ Yes _____ No
If yes, what was the outcome?_____

Did your child receive a diagnosis? _____ Yes _____ No
If yes, what was the diagnosis?_____

_____ _____
Client Name Therapists Signature Date

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Client Policy Statement

The fee for a one hour individual or family session is _____. Payment is expected at time of service. In the event you are filing insurance claims, receipts will be provided at the end of the month. Treatment may be suspended for lack of payment.

Clients have a right to expect that information revealed in sessions not be disclosed without extraordinary justification.

The conditions that justify release of information and by law must be reported to the appropriate agencies are the following:

1. Knowledge of child abuse or neglect.
2. Knowledge of senior citizen abuse or neglect.
3. A client poses a serious risk of suicide and is an imminent danger to self.
4. A client poses a threat of imminent danger to another person.
5. Judge, by issuance of a court order, may obtain information.

In all other situations a signed authorization for release of information is required.

Your appointment is reserved for you. Missed appointments are charged for at the rate of your sessions unless cancellation is received 24 hours in advance. Insurance may not be billed for missed appointments. Emergencies are not charged for such as illness or accident. If you need clarification of what constitute an emergency please discuss this with your therapist.

Telephone calls are often necessary in the practice of psychotherapy. Phone calls are not charged for unless they exceed 15 minutes. In the case that therapy is conducted over the phone, the session will be charged for at the regular session rate on a pro-rated basis.

I have read and understand the above stated policy statement and agree to enter treatment on these terms.

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

_____ _____
Therapist's Signature Date

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Personal Adjustment

Check the characteristics that are present in your child's life.

____Angry, defiant
____Avoids adults
____Bedwetting
____Bizarre behavior
____Blinking, jerking
____Bullies
____Clumsy
____Confident
____Cooperative
____Drug/alcohol use
____Easy-going
____Enthusiastic
____Expects failure
____Frequent daydreaming
____Frequent headaches
____Frequent injuries
____Fatigue
____Friendly
____Generous
____Impulsive
____Irritable
____Learning problems
____Lies frequently
____Loner
____Messy
____Often ill
____Overactive
____Overall depression
____Overweight
____Police problems
____Poor appetite
____Psychiatric problems
____Pulling out own hair
____Quarrels
____Sadness, crying
____Selfish
____Sets fires
____Sexual acting out
____Short attention span
____Shy
____Sleepwalking
____Sloppy hygiene
____Slow-moving
____Soiling
____Speech problems
____Steals
____Stomach aches
____Suicide attempt
____Suicidal gestures
____Tics or twitch
____Unusual thinking
____Weight loss
____Worries

_____

Child's Family

Relationship	Name	Age	Sex	Education	Employed	Marital Status
Father						
Mother						
Siblings						
Others in home(s)						

Who is the legal guardian? _____
Is there a formal parenting plan? _____yes _____no Please explain_____
_____

_____ _____
Client Name Therapist Signature Date

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What is the marital status of the child's parents?

____ 1.) never married
____ 2.) engaged to be married
____ 3.) married now for the first time
____ 4.) married again
____ 5.) separated
____ 6.) divorced and not remarried
____ 7.) widowed and not remarried
____ 8.) other (specify)_____

Financial:

Current source of income_____.

Have you or do you currently have financial problems ? ___yes ___no
Please describe_____

Legal:

Has the child ever been involved with the police or juvenile court? _____yes _____no
If yes, please explain_____
Are the parents involved in a divorce or custody issue currently? _____yes _____no
If yes, please explain_____

Spirituality:

Does the family have a religion? ___yes ___no If yes, what?_____
Does the child practice a religion? ___yes ___no If yes, what?_____
Was the family or child ever a member of a formal religion? ____yes ____no
Is a religious/spiritual community a resource for you? ____yes ___no

Cultural/Ethnic Information:

What cultural or ethnic group do you come from? Do you closely identify with this group and if so, do you see this as a strength? _____
Do you have any concerns about how your culture or ethnicity may affect therapy?
____yes ____no

Leisure Activities:

Hobbies or leisure activities
_____
_____

Play patterns _____
Has your child's play pattern or activity level changed recently? _____yes _____no

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Relating to Others:

Describe how your child relates to other people (e.g., easily, shy, leader, follower, outgoing, etc.)
_____

Does your child isolate from others? _____yes _____no
If yes, explain_____

Do the child's social activities include the use of drugs or alcohol? _____yes _____no
If yes, explain_____

Substance Abuse History

Does the child have a problem with alcohol or drugs? _____yes _____no
If yes, please explain_____

Has the child ever received substance abuse treatment? _____yes _____no
If yes, please explain_____

Is there a family history of substance abuse? _____yes _____no
If yes, please explain_____
_____
_____

Is anyone in your household currently misusing alcohol or drugs? _____yes _____no
If yes, please provide more details_____
_____
_____

_____ _____
Client Name Therapist Signature Date

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Other Things That We Should Know About Your Child

_____

_____

Developmental History (check all that apply)

During pregnancy: Any bleeding? _____ High blood pressure? _____
Pounds gained _____ Used tobacco? _____
Used alcohol? _____ Used drugs? _____
Explain _____
Sickness of mother during pregnancy? _____
Other difficulties? _____
Age of mother when the child was born _____

Birth: _____Full term _____Premature Weight_____ Length of labor _____
Type of delivery (e.g., breech, Cesarean, normal) _____
Condition of the child at birth? _____
Did the child have oxygen at birth? _____

What age did your child:
Walk alone _____ Use single word _____ Sentences _____
Toilet train _____ Tie shoes _____ Write letters _____
Write sentences_____

Has your child ever had
An eye exam? _____yes _____no Results_____
A hearing exam? _____yes _____no Results _____

Has your child ever had convulsions? _____yes _____no

Has your child experienced injuries/hospitalizations? _____yes _____no
If yes, explain _____
_____

Was your child adopted? _____ yes _____ no If yes, at what age? _____
Does your child know? _____yes _____no

Has either parent ever separated from the child? _____yes ____no
If yes, please explain_____

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Medical History

Name and address of your child's physician(s):_____
_____
_____

List any significant **medical diagnoses** and conditions your child has:_____
_____
_____

Do your child have any **allergies**? Yes ____ No ____
Please list your child's allerg(ies) and describe the allergic reaction (Use back if need more room.)_____
_____

When was your child's last complete **physical exam**?_____
Results of physical exam: _____
What prescription medications is your child taking presently, and for what purpose? (Use back if need more space.)

_____
_____
_____
_____
_____

Use of over-the-counter and herbal remedies?

_____
_____
_____

_____ _____
Client Name Therapist Signature Date