Brazoria County Counseling Center
120 E. Plum Angleton, Texas 77515
979 549 0889

Child - Intake Evaluation Form

Client's Name:_____ **D.O.B.**:_____

Chief Complaint:

__ Very Unhappy __ Impulsive __ fire Setting ___ Irritable __ Stubborn __ Stealing __ Temper Outbursts
__ Disobedient __ Lying __ Withdrawn __ Infantile __Sexual Issues __ Daydreaming __ Mean to Others
__ School Issues __ Fearful __ Destructive __ Truancy __ Trouble with the law __ Bed Wetting
__ Overactive __ Running Away __ Soiling pants __ Self Mutilating __ Eating Problems
__ Short Attention Span __ Head banging __ Sleeping Problems __ Distractible __ Sickly __Lacks Initiative
__ Shy __ Tobacco Use __Undependable __Strange Behavior __ Alcohol Use __ Strange Thoughts
__ Crying/Depression __ Phobia __ Suicidal Talk __ Dependency on Prescribed, Over The Counter Drugs
__ Other Drug Dependency

Other/Explain:_____
_____
How long has this been an issue?_____
_____
Problems perceived to be __ Very serious __ Serious __ Not Serious
What was the reason for seeking help at this time?_____
_____
What changes would like to be seen in the family?_____

Psychosocial History

Religious Affiliation that may affect therapy _____
Current Family Situation:
Mother: Relationship to child __ biological parent __ relative __ step-parent
__ adoptive parent __ foster parent __ mother not part of their life
Occupation:_____ Education: _____ Birthplace_____
Birthdate:_____ Age:_____
Father: Relationship to child __ biological parent __ relative __ step-parent
__ adoptive parent __ foster parent __ mother not part of their life
Occupation:_____Education: _____ Birthplace_____
Birthdate:_____ Age:_____

THERAPIST'S NOTES ONLY:_____
_____
_____
_____

Client's Name:_____ D.O.B.:_____

Marital Status of Parents/Guardians:

__ Married ___ how long Age: (Mom) __ (Dad) ____

__ Separated __ divorced (how long: ___) ___Deceased (Mom) __ (Dad) ___

How long ago:_____

If child is adopted/Foster Care:

Adoption/FosterCare Source:_____

Reason and Circumstances: _____

_____

Date of legal adoption:_____ Age child adopted:_____ Does child know: _____

What does child know:_____

Living Arrangements:

How many times has child/adult moved?_____

Places and length of time there? _____

Presently living: __ renting__ buying__ house __ apartment __ other

Does the child share a room?_____ If yes, with who?_____

Has child ever been placed, boarded, or lived away from the family?_____

Why?_____

Brothers and Sisters

Name	Age	Sex	(Full, Half, Step)	At Home	Present Grade
1.)					
2.)					
3.)					
4.)					
Deceased sibling: Sex, Name, Age of Death, Circumstances of death:					

Family History of Drug/Alcohol Abuse, Mental Health i.e Depression, Suicide, etc.

_____

_____

Significant Health Issue of a Family Member? If so, Explain:_____

_____

Client's Name:_____ D.O.B.:_____

Medical History:

Client Health Information: (all health problems in the past and present)

Illness/Surgeries/Hospitalizations/Serious Accident	**What Age**
1.)	
2.)	

Name of Primary Care Doctor: _____

Name of Specialist Seen (if applicable) _____

Name of medication	**Dose**	**Reason**	**Age Prescribed**	**Amt. of time on Medication**
1.)				
2.)				
3.)				
4.)				

Developmental History:

Prenatal:

Child Wanted: __Yes __ No Planned For: __ Yes _ No Normal Pregnancy __ Yes __ No

Was mother ill or upset during pregnancy? Explain_____

_____

Length of Pregnancy:_____ Paternal support during pregnancy and after: __ Yes __ No

Did mother abuse drugs or alcohol during pregnancy?_____

Birth: Length of active labor?_____ _ Easy __Difficult If premature, How early?_____

If overdue, how late? ____ Birth Wt?_____ Birth Ht?____

Delivery Type: _ spontaneous _cesarean _ with instruments __ head first __ breach

Was oxygen necessary? ___ Blood Transfusion___ Trauma to baby at time of birth? ___

Newborn Period:

Irritability: Yes__ No__ Vomiting: Yes__ No___ Difficulty Breathing: Yes __ No__

Difficulty Sleeping: Yes __ No__ Convulsions/ Seizures:Yes __ No__ Colic:Yes __ No__

Normal Weight Gain: Yes __ No __ Breast Fed Yes__ No___

Developmental Milestones:

At what Age was it accomplished:

Sat up _____ Bladder Trained_____ Bowel Trained _____Crawled____ Walked _____

Weaned from bottle_____Spoke single words_____ Sentences_____

Child potty training experience:_____

Client's Name:_____ D.O.B.:_____

Relationship to Siblings and Peers:

___ Independent ___ Group Play ___ Competitive __ Cooperative
___ Leadership Role ___ a Follower

Educational History

Name of School	City/St.	Grade Retained
Preschool		
Elementary		
Junior High		
High School		

Type of Classes:

__ Regular __ Advanced __ Special Education:___ learning Disability __ Emotional Issues
Did child skip a grade level?_____ Repeat a grade level?_____
If yes, Explain_____
_____
Did child have any specific learning difficulties? _____
Receive Tutoring __ Yes __ No Regular Attendance __ Yes __No Motivated __ Yes __ No
Behavioral Issues in School: _____
_____

Academic Performance:

Highest Grade on last report card?____ Lowest Grade on Report card_____
Favorite Subject:_____ Least Favorite Subject:_____
Child Involved in Extra Curricular Activities in School? If so, what activity and how long
_____
On average, how many friends does child have __ A lot __ Few ___ None
Child's Educational Aspirations: __ Drop Out __ Graduate H.S.___ Attend College
Has child had any special testing in school? ___ Yes ___ No
Psychological Testing: __ Yes __No Outcome:_____
Vocational Testing__ Yes __No Outcome:_____

Legal History

Has child had any difficulty with the police? If yes, explain_____
_____
Has child ever been on juvenile probation? If yes, explain_____
_____

Client's Name:_____ D.O.B.:_____

Has child ever been employed? If yes, where and how long_____

Child's Special Interests, Hobbies, Skills:_____
_____

Parent/Guardian Military History:
Is Parent Active Military __ Yes __No Combat History:__ Yes __ No
Branch_____ Discharge Date: _____Type of Discharge_____
Date Enlisted _____Rank at Discharge_____

********* **FOR THERAPISTONLY. DO NOT FILL IN PAST THIS LINE*******

Mental Status: (Check all that apply)
Orientation:__ Time _ Person __ Place __
Appearance: __ Neat __ Unkempt __ Bizarre
Mood: __ Relaxed __ Anxious __ Fearful __ Suspicious __ Depressed __ Ashamed
__ Guilty ___ Irritable __ Angry __ Happy/Euphoric
Affect: ___ Appropriate/igh __ Inappropriate __ Blunted __ Flat __ Constricted
Thought Process :__Coherent __ Confused __Obsessive__Tangential __ Flight of Ideas
__ Illogical __ Delusional __ Disorganized __ Hallucinating
Estimated Intelligence: __ High __ Average __ Borderline __ Low M/R
Insight : __Good __Limited __ Poor __ None
Judgment __ Good __ Fair __ Poor

Risk Assessment:
Suicidal __Current__ Ideation __ Plan __ Attempt(s) __None Currently
Explain _____
_____
Self Injurious __Current__ Ideation __ Plan __ Attempt(s) __None Currently
Explain _____
_____
Homicidal __Current__ Ideation __ Plan __ Attempt(s) __None Currently
Explain _____
_____
Assaultive __Current__ Ideation __ Plan __ Attempt(s) __None Currently
Explain _____
Source of Data:Client Self Report ___Client's Parent/Guardian ___Other (Specify)____

Diagnosis
Axis I:_____

Therapist's Signature and Credentials_____
Date_____ Start Time: _____ End Time: _____