HOPE In Home Counseling
PERSONAL INTAKE FORM- Child

Today's Date:_____

Name of Child:_____

Age:_____ Date of Birth_____ Place of Birth_____

School:_____ Grade_____

Parents Names_____

Address_____ Phone_____

Parent Email Address_____

Please list any physical illnesses, diseases, serious accidents or operations, including inpatient psychiatric care child has had:_____

_____

_____

_____

Who does child live with? How many siblings and ages

Has child had counseling before? Yes_____ No_____ When? _____

Where? _____

How is Your child's present physical condition? Good_____ Fair_____ Poor_____

Is child presently taking any prescription medications? Yes_____ No_____

Is child using non-prescription medications? Yes_____ No_____

Please list medications and dosages child is taking currently:

_____

_____

_____

Has child talked about suicide? Yes_____ No_____ How Often_____ Last Time_____

No___

Has child talked about homicide? Yes___ How Often_____ Last Time_____

Check any of the following symptoms that have been noticed: Bedwetting_____

Bite Nails_____ Nightmares_____ School Problems_____ Eating Problems_____

Lying_____ Aggressive Behavior_____ Anger/Rage_____ Depression_____

Cutting self_____ Runs Away_____ Crying_____ Sleep Problems_____

Have there been any significant losses/Stressors Yes_____ No._____

Child's personal strengths:

_____
_____
_____

Child's interests/leisure/extracurricular activities:

_____
_____
_____

Briefly explain the current problems or issues you have concerning you child

_____
_____
_____
_____
_____
_____

Parent Signature_____ Date_____

Witness_____ Date_____