Ferren Family Counseling LLC

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Child/ Teen Intake Form

Please provide the following information about your child:

Full Name: _____
Nick Name: _____
Birth Date: ____ /____ /____ Age: _____
Gender: _____ SSN:_____

Address: _____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? □ Yes □ No
Cell/Other 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.*

Referred by (if any): _____

Insurance: _____
ID#: _____ Group #: _____
Guardian/ Parent: _____

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.
_____
_____
_____

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

_____
_____
_____

Behavioral Assets:
What does your child do that you like? What does he/she do that other people like?

_____
_____
_____

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet?

_____
_____
_____

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

_____
_____
_____

Please describe any past counseling that either your child or any family member has had.

_____
_____

Family History:
The name of the child's biological parents:
Mother: _____ Father: _____
Who has legal guardianship of your child? _____

Who are the people living in the home with the child?

_____
_____

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____ if yes, please describe:_____

Education History:
What school does your child attend?_____
Address: _____
Phone: _____ Teacher's Name: _____
Current Grade: _____

What does your child's teacher say about him/her?
_____
Has your child ever repeated a grade? If so which one(s)?_____

Has your child ever received special education services?_____
_____

Has your child experienced any of the following problems at school:

Fighting	Lack of friends	Drug/Alcohol	Detention
Suspension	Learning Disabilities	Poor attendance	Poor grades
Gang influence	Incomplete homework	Behavior problems	

Medical History:
What is the name of your child's primary care physician? _____
Address: _____ Phone: _____
Date of your child's last medical examination: _____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, Please describe them:_____

Has your child experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness	Other	

Please list any current medical problems or physical handicaps:
_____
_____

Please list any medications your child takes on a regular basis:

_____

_____

Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal)? If so please describe:

_____

_____

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

_____

_____

Has he/she ever purposely hurt himself or another?

_____

_____

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

_____

_____

Finally, what are some of the things that are currently stressful to your child and his/her family?

_____

_____