Ole Towne Counseling & Assessment Services
Child Intake Form

***Please complete all questions on this form (Please Print)**

Today's date____/____/____

Name of person filling out this form: _____
Relationship to client

CLIENT INFORMATION

Child's Name: _____Date of Birth: ____/____/____

Address: _____

Email Address: _____

Home Phone: (____) _____Work: (____) _____Cell: (____)_____

Age: _____ Gender: □ Male □ Female

Race (optional) □ African American □ Asian □ Hispanic □ White □ Other _____
(specify)

Parents are currently □ Married □ Separated □ Divorced □ Remarried □ Never Married

Child's legal guardian is: _____

Mother's Name:_____ Age: _____ Education: _____

Address: _____
City Zip

Email Address: _____

Home Phone: _____Work: _____ Cell: _____

Father's Name:_____Age: _____ Education: _____

Address: _____
City Zip

Stepparent's Name (if applicable): _____

Address: _____

Home Phone: _____Work:_____Cell: _____
City Zip

Please list the names and ages of any siblings including step and half siblings: _____

_____

DEVELOPMENTAL HISTORY

Pregnancy

Please indicate any problems experienced during pregnancy _____

How old was the mother when she became pregnant? _____

Any alcohol, drug use or smoking during the pregnancy? □ Yes □ No If yes, please describe:

_____

Did the mother receive prenatal care? □ Yes □ No Was delivery induced? □ Yes □ No

How long was the labor? _____ Delivery was □ Vaginal □ Cesarean section

Please note any complications associated with the delivery, if applicable _____

_____

Was the child premature? □ Yes □ No If yes, by how many weeks? _____

Child's birth weight _____ If neonatal care was needed, please describe:_____

_____

Were there any feeding or sleeping issues after the child's birth? □ Yes □ No If yes, please describe _____

Please describe the child's temperament as an infant_____

_____

Toddler & Preschool years

During the child's first years, did he/she show any of the following behaviors? Check each that applies:

□ resisted cuddling
□ was not calmed when held
□ colicky
□ excessively restless
□ had poor sleep patterns
□ preferred to play alone
□ banged head often
□ constantly into everything
□ fine motor problems
□ gross motor problems
□ did not babble
□ insensitive to pain or cold
□ excessive fears
□ ignored toys
□ unusual speech
□ unaware of pain
□ did not speak

Has your child ever received counseling or psychological services? □ Yes □ No If yes, please indicate why treatment was sought, whom provided treatment and results: _____

_____. Has your child ever been prescribed medications for psychiatric or emotional problems? □ Yes □ No

If yes, by whom and what medications were prescribed, and treatment results:_____

_____

Please list your child's primary care physician: _____

Phone: _____

Please describe any current medical illnesses/ allergies or health-related concerns: _____

_____

Please list any current medications your child is taking:_____

_____

Please list any family history of mental illness or chemical dependency: _____

_____

_____

Educational History

Name of current school, grade level and teacher's name: _____

_____

Please check any of the following concerns your child **currently** exhibits:

□ difficulty with reading
□ difficulty with math
□ difficulty with spelling
□ difficulty with writing
□ difficulty paying attention in class
□ difficulty sitting still in class
□ difficulty awaiting his/her turn
□ difficulty getting organized
□ difficulty remembering things
□ difficulty respecting others' rights
□ forgets homework
□ problems getting along with teacher
□ problems getting along with peers
□ resists school attendance
□ homework refusal
□ loses things

Did the child attend preschool? □ Yes □ No If yes, at what age? _____ Location_____

Does your child have an IEP or 504 plan? □ Yes □ No

Has your child ever repeated a grade? □ Yes □ No

Social and Behavioral Development

Please place a check next to any behavior your child **currently** exhibits:

□ Difficulty with hearing
□ Difficulty with coordination
□ Difficulty with balance
□ Difficulty making friends

□ Difficulty keeping friends
□ Refuses to share
□ Prefers to be alone
□ Does not get along well with adults
□ Fights verbally with adults
□ Fights physically with adults
□ Yells and calls children names
□ Shows wide mood swings
□ Is aggressive (describe) _____
_____
□ Is withdrawn (describe) _____
_____
□ Is shy or timid □ Clings to others
□ Tires easily, has little energy
□ Is more interested in things than people
□ Engages in behavior that could be dangerous to self or others (describe) _____
_____
□ Breaks objects deliberately
□ Lies (describe) _____
_____
□ Steals
□ Injures self often
□ Has low self- esteem
□ Blames others for his/her troubles
□ Is argumentative
□ Fights verbally with other children
□ Complains of aches or pains
□ Is disobedient
□ Gets into trouble with the law
□ Constantly seeks attention
□ Is restless
□ Has periods of confusion and disorientation
□ Is jealous (describe) _____

□ Fights physically with other children
□ Does not show feelings
□ Has frequent crying spells
□ Has unusual or special fears or mannerisms (describe)
_____
□ Wets bed □ bites nails □ sucks thumb
□ Has frequent temper tantrums
□ Has trouble sleeping
□ Rocks back and forth □ Bangs head
□ Holds breath □ Is stubborn
□ Eats poorly
□ Has poor bowel control
□ Is much too active □ Is fidgety
□ Is easily distracted
□ Is disorganized
□ Is unusually talkative
□ Is forgetful
□ Has blank spells
□ Daydreams too much
□ Worries excessively
□ Is impulsive
□ Takes unnecessary risks
□ Gets hurt frequently
□ Has too many accidents
□ Doesn't learn from experience
□ Feels that he or she is bad
□ Runs away
□ Is slow to learn
□ Moves slowly
□ Does not get along with others
□ Stares into space for long periods
□ Engages in stereotyped behavior
□ Does not understand other's feelings
□ Has difficulty following directions
□ Gives up easily
□ Shows anger easily
□ Has difficulty accepting criticism
□ Feels sad or unhappy often

□ Is extremely selfish
□ Talks about wanting to die

□ Feels hopeless
□ Is nervous or anxious
□ Is immature
□ Is easily frustrated
□ Has difficulty learning when there are distractions
□ Is suspicious of other people
□ Requires constant supervision
□ Has difficulty resisting peer pressure
□ Drinks alcohol
□ Has poor attention span
□ Has poor memory
□ Sets fires
□ Is afraid of new situations
□ Has trouble making plans
□ Eats inedible objects
□ Is not toilet trained
□ Uses illegal drugs
□ Other problems (describe) _____
_____

Please describe any Trauma History:
_____

_____

What are your child's strengths? _____

_____

What activities does your child enjoy? _____

_____

What prompted you to seek services at this time? _____

_____

_____

Please add any other information you feel it would be helpful to share about your child_____

_____

_____

Please indicate your goals for treatment:

1. _____

2. _____

3. _____

Thank you for taking the time to complete this form. Your input will be invaluable in planning your child's course of treatment.

Whom may I thank for referring you? _____

Ole Towne Counseling & Assessment Services
601 Cedar St., Ste. 5
Beaufort, NC 28516

Initial Assessment Interview/Diagnostic Assessment –Child

Clinical presentation/behavioral observations during intake/Mental Status Examination:

Risk Assessment: Harm to self _____ Low _____ Medium _____ High

Harm to others _____ Low _____ Medium _____ High

Specific risk factors:

Other relevant information from child/family:

Diagnosis:

Locus/Calocus:

Recommendations/Preliminary Service Plan:

What natural, existing or community supports would the client likely use to help meet goals?

Clinician's signature: _____Date:_____
Maureen G. Migliore, MS, Licensed Psychological Associate