Paulette Sears Counseling, LLC
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Child Intake Form

Name _____ **Age** _____ **Birthdate** _____
Ethnicity _____

Parents
Mother _____ Age _____ Occupation_____

Deceased_____Age of death_____ Cause of death_____

Father _____ Age _____Occupation_____

Deceased_____Age of death_____ Cause of death_____

Brothers and Sisters (List name(s) from oldest to youngest)
_____
_____
_____

Who lives in your home? _____
_____
_____

Presenting Problem

State in your own words the nature of the problem you are seeking help for: _____
_____

When did the problem begin? (Approximate dates and circumstances): _____
_____
_____

What do you hope to accomplish through the counseling process?
_____

Current Concerns. Please circle any area where you think you may have a PROBLEM:

Anger/Temper	Anxiety/Nervousness	Stress	Parenting Skills	Guilt
Fears/Phobias	Behavior Problems	Self-Concept	Self-Injury	Recurring Nightmares
Indecision	Relationships	Depression	School Problems	Hopelessness
Irritability	Suicidal Thoughts	Weight Loss/Gain	Concentration	Memory
Mood Swings	Hyperactivity			

Other:_____

Name of Child_____ DOB:_____
Biological Child___ Adopted Child ___ Foster Care Child ___ (How long in your home?)
Child's School _____ Grade_____ Teacher _____
School Social Worker/Psychologist_____
What has the school informed you about your child's behavior and or academics?
_____
_____
_____
_____
What are your main concerns regarding your child? _____
_____
_____
_____

Developmental History
Was pregnancy of child planned? _____
Were there any problems during pregnancy? _____
Were there any complications during labor and delivery?_____
Did caregiver experience any depression during or after pregnancy? _____
Was child breast fed, if so, for how long? _____
At what age did child talk?_____ walk? _____ become toilet-trained? _____
Did caregiver experience any long separation from child (more than 2 weeks?)_____

Check yes or no if any of the following occurred during the first two years of the child's life. If yes, describe and fill in age of occurrence:

	Yes	No	Age of Child
Frequent or lasting painful illness	_____	_____	_____
Major Surgery	_____	_____	_____
Severe Colic lasting more than 1 month	_____	_____	_____
Hospitalization	_____	_____	_____
Physical Abuse	_____	_____	_____
Sexual Abuse	_____	_____	_____
Neglect of physical or emotional care	_____	_____	_____
Verbal abuse or threats of violence	_____	_____	_____
Switches in daycare	_____	_____	_____
Changes in primary caregiver	_____	_____	_____
Main caregiver struggled with parenting skills	_____	_____	_____
Depression or serious physical illness of caregiver	_____	_____	_____

Did or does the child have any of the following behaviors:

	Yes	No	Explain
Temper tantrums	_____	_____	_____
Unusual fears	_____	_____	_____
Daredevil behavior	_____	_____	_____
Sleeping problems	_____	_____	_____
Eating problems	_____	_____	_____
Stubborn	_____	_____	_____
Clumsy	_____	_____	_____
Shyness	_____	_____	_____
Impulsive	_____	_____	_____
Affectionate	_____	_____	_____
Easily Comforted	_____	_____	_____
Well-Coordinated	_____	_____	_____
Rocking back & forth	_____	_____	_____
Blank spells	_____	_____	_____

Any history of traumatic experiences of any nature? _____
_____
_____

Any previous testing or counseling (Dates, Place, Findings): _____
_____
_____

What are your child's strengths? _____
_____
_____

Does your child make and keep friends easily? _____
_____

Has your child ever been bullied by a peer? _____
_____

PHYSICAL HEALTH

Do you have any concerns about your child's physical health? Please Explain:
_____
_____
_____

Is your child under the care of a physician for treatment of a physical or emotional condition? _____
If yes, please list physician's name, reason for treatment, and date last seen _____
_____

Current Physician _____ Last Examination and Results:_____
_____

Any hospitalizations (where and for what)? _____
_____

Parenting

Describe your relationship with your child (past & present): _____
_____
_____

How do you feel about being a parent? _____

_____

How do you handle problems with your children? _____
_____
_____

What forms of discipline do you use? _____
_____
_____

To what extent do you rely on your children for support (emotional and/or financial)? _____
_____
_____

Do you have extended family members to whom you are able to turn for emotional support?
_____
_____

Recreation and Leisure:

What are your child's hobbies and/or interests? _____
_____
_____

How often does your child involve themselves in their hobbies and interests? _____
_____
_____

How often does your family vacation? _____

How often does your family sit down and eat a meal together? _____

Signature: _____ Date:_____