1878 Jeff Rd. NW – Ste J
Huntsville, AL 35806
Phone: 256-489-0044
Fax: 800-763-4201
www.lifestreamfamilycounseling.org

# LifeStream Family Counseling

## CHILD INTAKE ASSESSMENT FORM

IDENTIFYING INFORMATION

Child's name: _____

Date of birth: _____ Age: _____ Grade: _____

Race/ethnicity: _____ Religious affiliation: _____

Social security number: _____

Person(s) completing this form: _____ Today's date: _____

Referred by:_____

*IF YOU ARE INTERESTED IN DIRECT- PAY SLIDING SCALE PLEASE COMPLETE (available if I am not under contract with your insurance company):*
Income _____
Other Sources & Amount of Income (disability, VA, retirement, SSI, support, etc)_____

### INSURANCE

Name of Primary Insured _____ Their DOB _____

Pre-Authorization Required? □Yes □No

Insurance Company _____ SSN _____

Group Policy Number_____ ID # _____

Name of Secondary Insured _____ Their DOB _____

Pre-Authorization Required? □Yes □No

Insurance Company _____ SSN _____

Group Policy Number_____ ID # _____

Child's custodian/guardian(s) is/are: _____

Child's Home Address: _____

City _____ State _____ Zip Code_____

Home Telephone: _____ Other Phone (specify type): _____

Is it OK to contact you/child at home? □ yes □ no OK to leave a message? □ yes □ no

Special instructions? _____

Emergency Contact Name: _____ Relationship to Child: _____

Address: _____

City _____ State _____ Zip Code _____

Home Telephone: _____ Other Phone (specify type): _____

## MOTHER'S INFORMATION

Mother's name: _____ Date of birth: _____ Home phone: _____

Address: _____

Race/ethnicity: _____ Religious affiliation: _____

Highest Grade Completed: _____

Marital/relationship status (Check one):

□ Married □ Live with partner □ Single □ Separated/Divorced □ Widowed or □ Other: _____

Employment status (Check all that apply):

□ employed □ retired □ disabled □ student □ homemaker □ unemployed

If/When employed, what type of work does mother do? _____

Current employer is:_____

Years on Current Job: _____ Business Phone: _____

Is it OK to contact mother at work? □ yes □ no OK to leave a message? □ yes □ no

Special calling instructions? _____

## FATHER'S INFORMATION

Father's name: _____ Date of birth: _____ Home phone: _____

Address: _____

Race/ethnicity: _____ Religious affiliation: _____

Highest Grade Completed: _____

Marital/relationship status (Check one):

□ Married □ Live with partner □ Single □ Separated/Divorced □ Widowed or □ Other: _____

Employment status (Check all that apply):

□ employed □ retired □ disabled □ student □ homemaker □ unemployed

If/When employed, what type of work does father do? _____

Current employer is: _____

Years on Current Job: _____ Business Phone: _____

Is it OK to contact father at work? □ yes □ no OK to leave a message? □ yes □ no

Special calling instructions?_____

## STEP-PARENT'S INFORMATION

Step-parent's name: _____ Date of birth: _____ Home phone: _____

Address:_____Race/et

hnicity: _____ Religious affiliation: _____

Highest Grade Completed: _____

Marital/relationship status (Check one):

□ Married □ Live with partner □ Single □ Separated/Divorced □ Widowed or □ Other: _____

Employment status (Check all that apply):

□ employed □ retired □ disabled □ student □ homemaker □ unemployed

If/When employed, what type of work does father do? _____

Current employer is: _____

Years on Current Job: _____ Business Phone: _____

Is it OK to contact father at work? □ yes □ no OK to leave a message? □ yes □ no

Special calling instructions? _____

## REASON FOR SEEKING TREATMENT

Please briefly describe the problems your child is experiencing: _____

_____

_____

_____

What has happened to cause you to seek help NOW?_____

_____

_____

What do you hope to be able to do or achieve as a result of treatment? _____

_____

_____

What do you consider to be other stresses in your child's life? _____

_____

## HISTORY OF THE PROBLEM

When did your child first start experiencing the problem(s) that brought you to the clinic today?_____

_____

How often does the problem occur? _____

How long does it last? _____

Does your child have any thoughts of harming him/herself? □ No □ Yes

Has your child ever attempted to harm him/herself? □ No □ Yes If yes, please explain:

_____

_____

Does your child have any thoughts of harming someone else? □ No □ Yes

Has your child ever attempted to harm someone else? □ No □ Yes If yes, please explain:

_____

_____

Has your child ever had previous therapy/counseling of any kind? □ No □ Yes

If yes, when and for how long? _____

What concerns were addressed in therapy? _____

_____

Was this experience helpful (please explain)? _____

Has your child ever been hospitalized for emotional/behavioral problems? □ No □ Yes

If yes, when/where was this: _____

_____

Has your child been prescribed medications to control emotional/behavioral problems? □ No □ Yes

If yes, please list medications, when prescribed, and by whom: _____

_____

_____

To your knowledge, has your child experimented with alcohol/drugs? □ No □ Yes

Are you concerned that your child might have or be developing a problem with alcohol or drugs?

□ No □ Yes If yes, please explain: _____

_____

_____

## FAMILY

Has this child ever experienced any parental separations, divorces, or death? □ No □ Yes

If yes, when? _____ How old was the child at the time? _____

Please describe the circumstances. _____

_____

If parents are separated or divorced, who has custody of this child? _____

How often does the other parent see this child? ____ Weekly or more often

____ Once or twice a month

____ Few times a year

____ Never

Please list the age and sex for each sibling (including those deceased, and step-siblings):

Age Sex Relationship to Child Living at home?

_____ □ No □ Yes

_____ □ No □ Yes

_____ □ No □ Yes

_____ □ No □ Yes

_____ □ No □ Yes

_____ □ No □ Yes

Other than any children already indicated above and parents, who else lives in the child's household?

_____

_____

Has anyone in the child's family had treatment for emotional problems? □ No □ Yes

If yes, please briefly explain (who/when): _____

Has anyone in your family ever attempted or committed suicide? □ No □ Yes

If yes, please briefly explain (who/when): _____

## FAMILY HEALTH

Describe father's present health: _____

Describe mother's present health: _____

Have any family members had any of the following (PLEASE CHECK IF YES)?

If yes, please specify family member's relationship to this child.

☐ Cancer _____ ☐ Severe head injury _____

☐ Tourette's syndrome _____ ☐ Cerebral palsy _____

☐ Diabetes _____ ☐ Food allergies _____

☐ Heart disease _____ ☐ Alcohol/drug abuse _____

☐ High blood pressure _____ ☐ Kidney disease _____

☐ Behavior disorder _____ ☐ Migraine headaches _____

☐ Depression _____ ☐ Multiple sclerosis _____

☐ Mental Illness _____ ☐ Physical disability _____

☐ Mental retardation _____ ☐ Stroke _____

☐ Nervousness _____ ☐ Tuberculosis _____

☐ Seizures/epilepsy _____ ☐ Alzheimer's disease _____

☐ Reading problem _____ ☐ Other Learning Problem _____

☐ Speech/language problem _____ ☐ Sickle cell anemia _____

☐ Attention Deficit/Hyperactivity Disorder _____

☐ Sleep Difficulties _____ ☐ Tics _____

☐ Anxiety _____ ☐ Bipolar Disorder _____

☐ Other significant health or emotional problem: _____

What kinds of stressful events has your child experienced recently? _____

_____

_____

_____

What kinds of stressful events have family members experienced recently? _____

_____

_____

_____

## CHILD'S EDUCATION

School (name, address) Grade Age Teacher Approx. Grades

_____

Does your child receive any special education services: □ Yes □ No

If yes, describe difficulties addressed and services provided_____

_____

Describe any difficulties or problems your child is having in school: _____

_____

_____

## CHILD'S DEVELOPMENT

Pregnancy and delivery

Was this a planned pregnancy? ı No □ Yes

Was the mother under a doctor's care? □ No □ Yes

Number of previous pregnancies/miscarriages: _____

Describe any complications that occurred during the pregnancy: _____

_____

What drugs/medications were used during the pregnancy? _____

_____

At this child's birth, what was the mother's age? _____ Father's age? _____

Length of pregnancy: _____ weeks Birth weight: ____ lbs ____ oz.

Length of labor: _____

Child's condition at birth:_____

Mother's condition at birth: _____

Length of stay in hospital: Mother _____ days Child _____ days

Is this child adopted? □ No □ Yes If yes, please provide adoption history: _____

_____

_____

_____

Was this child breast fed or bottle fed? □ No □ Yes If yes, when was she/he weaned? _____

At what age was this child toilet trained? Days: _____ Nights: _____

Did bed-wetting occur after toilet training? □ No □ Yes If yes, until what age: _____

Did soiling occur after toilet training? □ No □ Yes If yes, until what age: _____

Describe sleep patterns or problems: _____

_____

Language difficulties? □ No □ Yes If yes, describe: _____

_____

Delays with child's walking? □ No □ Yes If yes, describe: _____

_____

As a young child, did your child have problems getting along with others? □ No □ Yes

If yes, describe:_____

_____

Where there other problems experienced during the child's first year? □ No □ Yes

If yes, describe:_____

_____

## CHILD'S MEDICAL CARE

Child's physician: _____ Telephone: _____

Address:_____

How often does this child see a doctor? _____ Date of last visit: _____

Is this child currently on any medication? □ No □ Yes

If yes, indicate type and reason: _____

_____

_____

Does your child have any history of the following (please check all that apply):

□ hospitalizations □ surgeries □ high fevers □ serious accidents

□ eye, ear, nose & throat problems □ digestive disorder □ head injuries □ seizures

□ loss of consciousness □ serious illness □ allergies

Please list below details of any conditions you checked above, including any additional childhood illnesses and other medical conditions:

_____

_____

_____

Condition/hospitalization Age Treated by whom? Outcome of treatment

_____

_____

## CHILD'S INTERESTS AND ACTIVITIES

Is this child involved in any extracurricular activities, such as school sports or music programs, clubs or religious organizations? □ No □ Yes If yes, please describe: _____

_____

_____

Please describe your child's strengths and positive characteristics: _____

_____

_____

_____

_____

Other information you feel is important and wasn't asked about: _____

_____

_____

Thank you for your time and cooperation.

N. Gail Seemann, MS, LPC