Solomon Family Services
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Child Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Date: _____ Person completing Form: _____

Childs name: _____ _____ _____
(Last) (First) (Middle Initial)

DOB: ___/___/___ Age: _____ Male: _____ Female: _____ Grade: _____

Address: _____

City, State, Zip _____

Home Phone Number: _____

Mother: _____ DOB: ___/___/___

Address (If different): _____

City, State, Zip: _____

Home Ph: _____ Work Ph: _____ Cell: _____

Occupation: _____ Employer: _____

Father: _____ DOB: ___/___/___

Address (if different): _____

City, State, Zip: _____

Home Ph: _____ Work Ph.: _____Cell: _____

Occupation _____ Employer: _____

Emergency Contact:

Name: _____ Home Phone: ( ) -

Cell: ( ) - Work Phone: ( ) -

What is the best way to contact you to confirm an appointment for your child?

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 be aware that email might not be confidential.

People living in child's home

Name	Relationship to Child	Age	Occupation	Does child get along with this person?

Immediate family members living elsewhere (biological parent, sibling, half/step siblings)

Name	Relationship to Child	Age	Occupation	Does child get along with this person?

What concerns do you have about your child? _____

_____

_____

How long has this been going on? _____

Does Anyone else have concerns about your child?_____

If so who _____ What are their concerns _____

_____

_____

What do you think might be causing this? _____

_____

Describe your relationship with the child's other biological parent_____

_____

_____

Is the child adopted? □Yes □ No When: ___/___/___

Does the child know he/she is adopted? □Yes □ No

Any serious marital problems leading to separation? □Yes □ No

Date of separation: ___/___/___ Date of Divorce___/___/___

Length of marriage to child's biological parent: _____

Who has legal authority to seek psychological services? _____

Date of remarriage: Mother ___/___/___ Father ___/___/____

Name of step parents if any: _____

Are step parents allowed to participate in child's therapy?

Step Mother: □Yes □ No

Step Father: □Yes □ No

Has your child had previous psychotherapy/play therapy? □Yes □ No
If yes, Therapist's Name:_____ Therapists Phone Number: _____

Is your child currently taking prescribed psychiatric medication (antidepressants or others)?

□Yes □No

If Yes, please list: _____

If No, have your child previously been prescribed psychiatric medications?

□Yes □No

If yes, please list: _____

Physician Information

Pediatrician: _____ Phone: _____

Prescribing Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Last seen by pediatrician: _____

Is your child currently being treated for any medical problems or taking any other medications?

If yes, please explain _____

_____

Was there anything that caused either parent significant unhappiness or worry during the child's first three years? _____

_____

Is your child having any problems in the following areas?:

Bed-wetting or Bowel control	□Yes	□ No	
Eating	□Yes	□ No	
Sleeping	□Yes	□ No	
Fears	□Yes	□ No	
Separation problems	□Yes	□ No	
Thoughts of hurting self or others	□Yes	□ No	
Any deaths your child has experienced?	□Yes	□ No	If yes who? _____
Any moves? If so list dates	□Yes	□ No	_____

Describe any physical, sexual, emotional or verbal abuse_____

_____

_____

Child's reaction to birth of siblings? _____

_____

Any history of mental illness OR addictions in the family, diagnosed or undiagnosed in child's blood relatives (e.g. parents, grandparents, siblings, aunts, uncles, cousins)?
If Yes please explain.

_____

_____

_____

Describe any serious health problems or injuries in family: _____

_____

Child exposed to disaster? Explain_____

_____

What do you consider has been the biggest struggle in your family?_____

_____

What extracurricular activities is your child involved in?_____

_____

Describe your style of discipline_____

_____

Does your child have any responsibilities? □Yes □ No If yes List _____

_____

List your child's favorite activities? _____

_____

What does your child like the most? _____

_____

What does your child dislike the most? _____

_____

What are your child's character qualities?_____

_____

What do you admire most about your child?_____

_____

What activities does each parent do with the child that both child and parent enjoy?

Mother: _____ How often? _____

Father: _____ How often? _____

Please rate your child's development in the following areas:

	Below Average	Average	Above Average
Social			
Emotional			
Intellectual			
Physical			
Language			

Name of Child's school_____ Special Class? □Yes □ No

Current school Academic performance: □ Above Average □ Average □ Average □ Failing
Current school Behavior performance: □ Above Average □ Average □ Average □ Failing

Please describe any academic or behavioral problems your child is experiencing in School.

_____

_____

_____

When did these begin? _____ Repeated a grade? □Yes □ No Which one? _____

Has your child changed schools for any reasons? □Yes □ No If yes why? _____
_____

Additional comments or concerns:_____
_____

What are your goals of therapy? _____
_____
_____
_____

I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES REGARDING THE ABOVE INFORMATION.

BY SIGNING THIS COUNSELING, SERVICES AND INFORMED CONSENT, I THE UNDERSIGNED PARENT OR GUARDIAN, ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL THE TERMS AND INFORMATION CONTAINED HEREIN. I HAVE HAD THE OPPORTUNITY FOR CLARIFICATION AND DISCUSS ANYTHING UNCLEAR TO ME.

PARENTS /PRINTED NAME: _____ DATE: _____

PARENTS / SIGNATURE: _____ DATE: _____

COUNSELOR SIGNATURE: _____ DATE: _____