Firefly Play Therapy Registration Form

Client Intake Form

Today's Date

How did you hear about The Kid Counselor?

- ◯ Family
- ◯ Friend
- ◯ Internet Search
- ◯ Referral (Doctor/Professional)
- ◯ Other:

Child's Information

First Name

Middle Initial

Last Name

Is this his/her legal name

- ◯ Yes
- ◯ No

If not, what is his/her legal name?

Birthdate

Age

Sex

- ◯ Male
- ◯ Female

Street Address

City

State/Zip

School

Grade

Teacher's Name

Name of primary physician

Has your child ever been hospitalized? If so, please give date and describe

Please list any medications your child is currently taking

Please list any medication your child has taken for emotional or behavioral reasons

Please list any learning difficulties or other diagnoses that your child has

Parent Guardian Information

Your relationship to the child

Mother's name

Birthdate

Address (if different)

Phone (mobile preferred)

Occupation

Employer

Highest level of education completed

- ◯ High school/GED
- ◯ Some college
- ◯ College graduate
- ◯ Post graduate

Mother's marital status (Married/Divorced/Separated/Widowed/Other)(if remarried, spouse's name)

Father's name

Birthdate

Address (if different)

Phone (mobile preferred)

Occupation

Employer

Highest level of education completed

- ◯ High school/GED
- ◯ Some college
- ◯ College graduate
- ◯ Post graduate

Father's marital status (Married/Divorced/Separated/Widowed/Other)(if remarried, spouse's name)

Number of siblings

Sibling information (name, age)

In Case of Emergency

Name of local friend or relative not living at same address

Relationship to the child

Phone (mobile preferred)

Pediatric Symptom Checklist

	Never	Sometimes	Often
Complains of aches and pains	○	○	○
Spends more time alone	○	○	○
Tires easily, has little energy	○	○	○
Fidgety, unable to sit still	○	○	○
Has trouble with teacher	○	○	○
Less interested in school	○	○	○
Acts as if driven by a motor	○	○	○
Daydreams too much	○	○	○
Distracted easily	○	○	○
Is afraid of new situations	○	○	○
Feels sad, unhappy	○	○	○
Is irritable, angry	○	○	○
Feels hopeless	○	○	○
Has trouble concentrating	○	○	○
Less interested in friends	○	○	○

Fights with other children	○	○	○
Absent from school	○	○	○
School grades dropping	○	○	○
Is down on himself/herself	○	○	○
Visits the doctor with doctor finding nothing wrong	○	○	○
Has trouble sleeping	○	○	○
Worries a lot	○	○	○
Wants to be with you more than before	○	○	○
Feels he/she is bad	○	○	○
Takes unnecessary risks	○	○	○
Gets hurt frequently	○	○	○
Seems to be having less fun	○	○	○
Acts younger than children his/her age	○	○	○
Does not listen to rules	○	○	○
Does not show feelings	○	○	○
Does not understand other people's feelings	○	○	○
Teases others	○	○	○
Blames others for his/her troubles	○	○	○
Takes things that do not belong to him/her	○	○	○
Refuses to share	○	○	○

Has your child ever had problems with any of the following

	Age of onset
Eating	○
Sleeping	○
Illness/Disease	○
Serious Injury	○
Traumatic events	○
Exposure to violence in the home	○
Physical or sexual abuse	○
Depression	○
Anxiety	○
Disrupting thoughts	○

Briefly describe any problems that you checked above

Please list your current concerns about your child

Has your child ever seen a counselor other than a school counselor? If so, give name and date

How many times have you moved in the last 3 years?

Besides you, does anyone else take care of the child? If yes, who?

How do you rate this child's health in general?

	1	2	3	4	5	
Poor	○	○	○	○	○	Excellent

Do you feel you live in a safe environment?

- ○ Yes
- ○ No

In the past year, have you felt threatened in your home?

- ○ Yes
- ○ No

Do you ever have 5 or more drinks at one time?

- ○ Yes
- ○ No

Have you ever had a drug problem?

- ○ Yes
- ○ No

How often does your family eat meals together?

	1	2	3	4	5	
Never	○	○	○	○	○	Always

What does your family do together for fun?

How strong are your family's religious beliefs or practices?

	1	2	3	4	5	
Not at all	○	○	○	○	○	Very Strong