Family Counseling Service of Northern Utah
A United Way agency serving Weber, Morgan, Box Elder & Davis counties

CHILD INTAKE FORM

TO BE COMPLETED BY PARENT OF LEGAL GUARDIAN Today's Date: _____

CHILD DEMOGRAPHIC INFORMATION

Client Name: ❒ Male ❒ Female

Age (Yrs.): ❒ 0-5 ❒ 6-11 ❒ 12-17

Ethnicity : ❒ White ❒ Hispanic ❒African American ❒ Asian ❒ Pacific Islander ❒ Native American ❒ Other _____

County of Residence: ❒ Weber ❒Davis ❒Morgan ❒ Box Elder ❒ Other _____

Are you a refugee: ❒ Yes ❒ No

Child's Biological Parents:
Mother's Name:_____ Father's Name:_____
Child's Legal Guardian:_____

Child currently <u>lives with</u>: (biological family, relatives, foster care, etc.)

Name	Sex	Relationship to Child	Age
	❒ M ❒ F		
	❒ M ❒ F		
	❒ M ❒ F		
	❒ M ❒ F		

List significant others <u>NOT</u> living with the child

Name	Sex	Relationship to Child	Age
	❒ M ❒ F		
	❒ M ❒ F		
	❒ M ❒ F		

Past counseling received by child or other family member:_____ Date: _____
Reason: _____

Outcome : _____

CHILD MEDICAL HISTORY

Child's medical doctor:

_____

Address: _____ Phone: _____ Date of child's last medical examination:

_____

Family use (current and/or past) of any drugs, tobacco or alcohol/ Explain:

_____

_____

_____

_____

Describe including quantity and frequency of substance:

_____

_____

_____

Did biological mother smoke, use alcohol, drugs or medications during pregnancy? (List which substances including quantity and frequency.). Explain:

_____

_____

_____

Did biological mother have any problems during pregnancy or delivery? If so, describe those problems:

_____

_____

_____

Has the child experienced any of the following medical problems? Please check all that apply:

☐ Serious accident	☐ Hospitalization	☐ Surgery
☐ Head injury	☐ High fever	☐ Asthma
☐ Eye/ear problems	☐ Meningitis	☐ Allergies
☐ Convulsions/ seizures	☐ Loss of consciousness	☐ Hearing problems

☐ Other _____

List current child medical problems or physical handicaps:

_____

_____

_____

List child's regular medications including quantity and frequency of dosage:

_____

_____

CHILD EDUCATIONAL HISTORY

Child's School: _____

School Address: _____

Teacher's Name: _____

Current Grade: _____ Phone: _____

Teacher's current evaluation of child:

_____

_____

_____

Other schools attended (including pre-school):

_____

_____

_____ Has the child ever repeated a grade: _____ If so, which one? _____

List special education services if applicable:

_____

_____

List child's problems at school, please check all that apply:

- ☐ Fighting
- ☐ Suspension
- ☐ Gang influence
- ☐ Lack of friends
- ☐ Learning disabilities
- ☐ Poor attendance
- ☐ Poor grades
- ☐ Incomplete homework
- ☐ Behavior problems
- ☐ Detention
- ☐ Drug/alcohol
- ☐ Other_____

BEHAVIOR FACTORS:

Excess. What misbehaviors does child currently display too often, too much or at the wrong times? (List all significant behaviors)

Deficits. What does child fail to do as often as you would like, as much as you would like or when you would like? (List all significant behaviors)

Assets. What does child do that you or others like?

List any other concerns about your child and/or family;

Has child ever experienced abuse? (Physical, emotional, sexual or verbal) If so, describe:

Has child ever made statements of wanting to seriously hurt self or another? Has child ever purposely hurt self or another? If yes to either question, describe situation:

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Has child ever experienced serious emotional losses (deaths, separations, etc.)? If yes, explain:

What things currently stress child and/or child's family?

TREATMENT GOALS

What child problem behavior(s) do you want addressed first in therapy and how much positive change will satisfy you?

Signature of Parent or Legal Guardian

Date

Therapist Signature

Date