Harmony Counseling Center PLLC
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(734) 644- 6943

Child Intake Form

Please provide the following information about your child:

Child's Name: _____ Date:_____

Birth date: _____/_____/_____ Age: _____ Gender _____

Address: _____

City, State: _____ Zip: _____

Parent/ Guardian Name(s): _____

Home Phone: (_____) _____ May I leave a message? □Yes □ No

Cell/Other Phone: (_____)_____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

School: _____ Grade:_____

How does your child do in school academically? _____

_____

_____

How does your child do in school behaviorally? _____

_____

_____

Does your child have a learning or physical disability? □Yes □No □ Maybe.
Specify:

_____

_____

Does your child have a mental health diagnosis? □Yes □No Specify:

_____

_____

Does your family have specific spiritual beliefs?_____

Medical History

During pregnancy, did mother use: □Cigarettes □Alcohol □Drugs □Experience Extreme Stress?

Specify frequency, amounts, and duration: _____

List any birth complications (Ex: Premature, jaundice, C-section, etc.)_____

_____

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)_____

_____

Does child use: □Cigarettes □Alcohol □Drugs

Specify amount and frequency: _____

Primary Care Physician: _____ Phone:(_____)_____

Last seen on: _____

Current medications: (Include dosage and frequency): _____

_____

Medication Allergies: _____

Other Allergies: _____

If yes, please specify:

_____

_____

Reached developmental milestones: □On time □Early □Late

Family History

Parent/Gaurdian 1:_____

Parent/Gaurdian 2:_____

Siblings:

Name: _____ Age:_____

Name: _____ Age:_____

Name: _____ Age:_____

Name: _____ Age:_____

People in household, if different from above: _____

_____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.): _____

_____

_____

Trauma History

Has your child been verbally abused? □Yes □No □Suspected. Specify: _____

_____

Has your child been physically abused? □Yes □No □Suspected. Specify:_____

_____

Has your child been sexually abused? □Yes □No □Suspected. Specify:_____

_____

Other stressors or traumas? _____

_____

Circle the symptoms your child/adolescent displays and list the number of times per week it is displayed:

Anger	Anxiety	Bed wetting
Acts out sexually	Conduct problems	Day wetting
Defiance	Depression	Suicidal Thoughts
Homicidal thoughts/actions	Disassociates	Drug or alcohol use
Hyperactivity	Masturbates excessively	Hyper vigilance
Self-harming behaviors	Isolation	Lack of empathy
Lack of motivation	Lethargy	Low impulse control
Plays out violent themes	Low self-esteem	Lying
Nightmares	Plays out sexual themes	Obsesses
Over/Under eating	Phobias	Peer problems
Phobias	Running Away	Shy
Sleeplessness	Stealing	Tantrums

Somatic Symptoms: Headaches/Stomachaches, etc.

Other: _____

_____

How does your child/adolescent handle anger? _____

_____

_____

Has the child/adolescent experienced any significant loss (i.e., death of or physical separation from a parent or other caretaker)? If yes, explain: _____

_____

_____

Personal History

What do you view as your child/adolescent's major strengths and positive traits?_____

_____

_____

What are your child/adolescent's hobbies? _____

_____

_____

What are your child/adolescent's responsibilities at home? _____

_____

How well does your child/adolescent handle these responsibilities? _____

_____

Briefly describe your goals for your child/adolescent's therapy: _____

_____

_____

Please list any information you deem to be important for the therapist to know: _____

_____

_____

Who shall I contact in case of emergency?

Name: _____

Phone (_____)_____

Relationship _____

I hereby consent for Harmony Counseling Center PLLC to provide my child/adolescent with treatment:

Client: _____ Date: _____

Parent/Guardian: _____ Date: _____

Therapist: _____ Date: _____