Janet Nordine, MS, LMFT, RPT-S
Experience Courage Therapy
702-630-8848 www.experiencecourage.com

CHILD THERAPY INTAKE FORM

Please complete on behalf of your child

Name of person completing this form: _____
Your relation to the child: _____
Phone: _____ Email: _____
Name of other parent/legal guardian: _____
Phone: _____ Email: _____
Child's first name: _____ Last name: _____

Child's Preferred Name _____ Pronouns _____

Age: _____ Birth day: _____ Month: _____ Year: _____
Ethnicity: _____ Religion: _____ Sex/gender: _____

Home address: _____
Who does your child live with? _____

Is your child Adopted Yes No

Does your child know that they are adopted? Yes No

If yes, please complete:

At what age did the removal from biological parent occur? _____

At what age did the child come to live in your home? _____

Was the child in foster care? Yes No, if yes, how long _____

If yes, how many placements prior to your home? _____

ACADEMIC INFORMATION: Name of child's school: _____
Grade/year: _____ Program: _____
Typical grades: _____ Last Year's Grades _____

Favorite Subject _____ Least Favorite Subject _____

Lunch time routine _____

HOW YOU WERE REFERRED: ♦ Word of mouth ♦ I'm a former client ♦ Psychology Today ♦
Professional Referral _____ • Google, using these words: _____

♦ Other: _____

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THE REASONS FOR YOUR CHILD'S VISIT:

_____
_____
_____
_____
_____

How intense is your child's emotional distress? (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe) Please describe:

_____

_____
_____
_____

Overall, how much do the problems affect your child's ability to perform school, get along with others, and perform daily tasks such as chores? (Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)

Please describe: _____

_____

When did these problems start? What was going on in your child's life at that time?

_____
_____
_____
_____
_____

PSYCHIATRIC AND MEDICAL HISTORY Please list any psychiatric or "mental" problems your child has been diagnosed with:

_____
_____
_____

Please list any medical or "physical" problems that your child has been diagnosed with:

_____
_____
_____

Please list any medications your child currently takes, and what they are taken for:

_____
_____

Name of Family doctor: _____ Phone: _____ Last check-up was during the month of: _____ Year: _____ Results:

_____

_____

Name of Psychiatrist: _____ Phone: _____ Last visit was during the month of: _____ Year: _____

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MENTAL HEALTH TREATMENT HISTORY Has your child ever been hospitalized for psychological or psychiatric reasons? ♦ No ♦ Yes If yes, please describe when and where, and for which reasons.

_____

_____

_____

Please tell us about any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

_____

_____

_____

_____

_____

_____

CURRENT HABITS Please describe your child's current habits in each of the following areas:

TV use: _____How long daily?_____

Internet use: _____ How long daily?_____

Video game use:_____ How long daily?_____

Caffeine intake: _____What? _____How much daily? _____

Energy Drinks: _____What? _____How much daily? _____

Exercise: _____

Eating: _____ Binge? _____Purge? _____

Sleeping: _____How many hours per night? _____

Difficulty falling asleep? _____ Staying asleep? _____

Fun and relaxation: _____

Chores and responsibilities: _____

Smoking: _____What?_____ How often?_____

Drinking: _____What?_____ How often?_____

Drug use: _____What?_____ How often?_____

Anything else? : _____

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RELATIONSHIPS Please describe your child's relationships with each of the following people, *if applicable:*

Adopted Mother: _____

Adopted Father: _____

Biological Mother: _____

Biological Father: _____

Step-parents: _____

Legal guardians: _____

Siblings: _____

Extended family: _____

Your children: _____

Friends: _____

Romantic partner(s): _____

Peers or classmates: _____

Total number of close, supportive relationships: _____

STRESSFUL LIFE EVENTS Please describe any significant or stressful life events that your child has been experiencing with either "No or Yes" If yes, please describe

A recent move or change in school? _____

Abuse or neglect? _____

Bullied or ignored by peers? _____

Academic difficulties? _____

Weight control issues? _____

Sexual orientation concerns? _____

Self-injury? _____

Death or Illness of a loved one or pet? _____

Family conflict? _____

Separation or Divorce? _____

Adoption? _____

Other? _____

What are your child's positive qualities and skills?

What do you like about your child? What qualities have helped your child to succeed at overcoming difficulties in the past? Please tell us about your child's interests (sports, hobbies, talents, etc.)

Does your child agree that the problem that she or he is seeking help for is problematic? What are some goals for your child's therapy?

What would you like them to achieve by attending therapy? What concerns do you have about your child attending therapy or working on these problems?

Is there anything else that you would like to mention?

Print Name:_____ Signature:_____

Date:_____