Shirin Shahrokhi
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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: _____

Age: _____ Birth day: _____ Month: _____ Year: _____

Ethnicity: _____ Religion: _____ Sex/gender: _____

Home address: _____

Who does your child live with? _____

ACADEMIC INFORMATION:

Name of child's school: _____ Grade/year: _____

Program: _____ Typical grades: _____

HOW YOU FOUND THIS THERAPIST:

☐ Word of mouth ☐ I'm a former client ☐ Order of Psychologists (OPQ) ☐ Psychology Today

☐ Rate MDs ☐ CJAD 800 ☐ 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?

_____

_____

_____

_____

_____

_____

_____

_____

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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: _____

Results: _____

_____

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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:

Smoking:
Drinking:
Drug use:
TV use:
Internet use:
Video game use:
Caffeine intake:
Exercise:
Eating:
Sleeping:
Fun and relaxation:
Chores and responsibilities:

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RELATIONSHIPS

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

Biological Mother:

Biological Father:

Step-parents:

Legal guardians:

Siblings:

Extended family:

Your children:

Friends:

Romantic partner(s):

Colleagues 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:

	No	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?			
Other?			

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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?