Date:_____/_____/_____

SPARROW HOUSE
COUNSELING

Child/Adolescent Intake Information

Child's Name_____
Last First Middle

Child/Adolescent Phone Number: _____

Child's D.O.B.____/_____/_____ Age:____ Sex:____ Place of Birth:_____

Home Address:_____
Street City State Zip

Parent's / Guardian's Names: _____

Parent Phone Number :_____/_____/_____
Home Work Cell

Parent e-mail address: _____

May I contact you and leave a message via: Hm Phone: Yes___ No___ Cell Phone: Yes_ __No___
May I e-mail you: Yes___ No___

Parent's Marital Status: Single Married Re-Married Divorced Widowed

If parents are divorced or deceased: Year Divorced _____ Year Deceased_____

If Divorced, who has physical custody?_____ Who has legal custody?_____

If Divorced, do you have the sole ability to make medical and psychological treatment decisions for you child?
_____

*Please note that Texas statutes for Counselors now require that the divorce decree as well as the custody agreement be on file before services with a minor client can commence. Please attach a copy for your child's counselor.

Please list siblings (Clarify if living in home by "IN" beside name): (Circle)

_____ Age: _____ DOB ____/____/____ Gender ___ Biological/Adopted/Step

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_____ Age: _____ DOB ____/____/____ Gender ___ Biological/Adopted/Step

Parent's / Guardian's Employer:_____ Position _____

Please list any other significant adult relationships where the child spends a large quantity of time (e.g. grandparent, aunt/uncle, nanny).

_____

_____

Religion as a child:_____ Currently:_____

Referral Source: _____/_____

Name Address

If someone referred you to our office, I would like to thank him or her for the referral. May I have permission to send a thank you note? Yes_____ No_____

Person to contact in case of emergency:_____ Telephone:_____

Concerns

What is your major concern that led you to seek help?

_____

_____

_____

What other concerns do you have?

_____

_____

_____

When were these difficulties first noted? Frequency of behavior?

_____

_____

_____

Has your child had previous psychological/psycheducational evaluations, past psychological/ psychiatric treatment, or psychotherapy? (Please Describe)

Medical History

Please describe your child's general health

Please note any serious accidents, concussions, illnesses or injuries

Any Hospitalizations?

Any conditions that require regular medical care?

Does this child take any medications? If so, please note type and frequency of use.

Developmental History

Please note any complications during pregnancy.

If adopted, please describe circumstances surrounding child's placement into your home (type of adoption--domestic, international, foster care, contact with birth parent, and age of child at placement).

How would you describe your child as an infant?

Any problems with motor development? (learning to walk, coordination)

_____

_____

Has this child had any problems with understanding or speaking language?

_____

_____

Does this child have any problems with soiling or wetting during the day or night? If so, please explain.

_____

_____

Does the child have current sleep disturbances? (Difficulty falling asleep, getting up in the middle of the night, or being difficult to wake?)

_____

_____

_____

Learning Development

Name of your child current school and all past schools attended with dates of attendance.

_____

_____

Does the child have frequent absences from school?_____

Has the child had to repeat a year in school?_____

Briefly describe how the child is doing in school noting areas of strength or weakness.

_____

_____

Describe your child's attitude towards school.

_____

_____

How does this child get along with the teacher? Other students?

_____

_____

Please check all responses that describe your child:

o Restless/Inattentive	Immature	Sad
Humorous/Fun	Aggressive	Disruptive
Cheerful	Forgetful	Happy
Daydreamer	Quick to Anger	Nervous/Tense

Please check if you have concerns about the following:

o Speech	Relationship with Peers
Eating	Ability to Learn
Sleeping	School Adjustment
Activity Level	Anxiety
Coordination	Degree of Responsibility
Aggressiveness	Destructiveness
Sexual Activity	Physical Health
Response to Discipline	Fears
Bladder Control	Bowel Function
Temper Tantrums	Lying
Stealing	Fire Setting
Thumb Sucking	Tics
Drugs	Truancy
Self-Injurious Behavior	Other_____

Please elaborate on any concerns that you have checked above:

_____

_____

What type of discipline strategies do you use with your child: time out, removal of privileges, spanking, reasoning with your child, talking to your child, bribing, not sure) Briefly describe.

_____

_____

DISORDER	IMMEDIATE FAMILY MEMBER	EXTENDED FAMILY MEMBER
Anxiety		
Depression		
Obsessive Compulsive Disorder		
Bipolar Disorder		
Schizophernia		
Social Anxiety		
Separation Anxiety		
Phobias		

DISORDER	IMMEDIATE FAMILY MEMBER	EXTENDED FAMILY MEMBER
Psychosis		
Autism Spectrum Disorder		
Seizure Disorder		
Learning Disabilties		
Language Disorder		
Motor Tics		
ADHD		
Trauma		
Behavioral Difficulties in Youth		
Eating Disorders		
Suicide		
Substance Abuse (drugs or alcohol)		
Other		

Research has shown that heredity plays a role in many disorders. Please take time to think of your various blood related relatives. Indicate any who have had similar symptoms as your child.

Is there anything else that would be helpful for me to know about? _____

_____

_____

What do you hope or expect child to gain from therapy?

_____

_____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes regarding the above information.

PARENT'S / GUARDIAN'S SIGNATURE_____ DATE_____