Journey Professional Counseling

Child Intake Assessment

Client Information

Child's Last Name:	**First Name:**	**Middle Initial:**
Date of birth:	**Gender: Male ___ Female ___**	**Child lives with:**
How did you hear about Journey Professional Counseling?		

Parental Information

Parent's name:		
Home phone:	**Cell phone:**	
Address:		
City:	**State:**	**Zip:**
Employer:	**Work phone:**	
Email:		
Parent's name:		
Home phone:	**Cell phone:**	
Address:		
City:	**State:**	**Zip:**
Employer:	**Work phone:**	
Email:		
Who will be responsible or making/keeping appointments?:		
Ok to leave phone message? Yes _____ No_____ Which number?		
Ok to send mail? Yes _____ No _____		
Ok to email? Yes _____ No_____		

Emergency Contact

Name of a person to contact in case of an emergency:		
Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Relationship:**	
Child's primary care provider:	**Phone number:**	
Child's school:	**Teacher:**	**Grade**
Phone number:		

Medical History			
Current Medications	**Dosage/Frequency**	**Start date**	**Purpose**

Has your child ever been hospitalized for medical or psychiatric reasons?
Yes ___ No ___ If yes, please explain:

Therapy Goals

Briefly discuss what brings you and your child in today?

What have you tried that isn't working?

What would you like to be different?

Who supports you and your family in your decision to begin counseling?

How will we know when we are done with counseling?

Risk Assessment
Has your child expressed wanting to hurt themselves or someone else?
Are you concerned with your child wanting to hurt themselves or someone else?
Are there weapons in your home? Yes ___ No ___ If yes, are they kept in a secured location? Yes ___ No ___

Family History		
Siblings Name:	**Age:**	**Currently live at home:**
		Yes _____ No _____
		Yes _____ No _____
		Yes _____ No _____
		Yes _____ No _____
		Yes _____ No _____
List any additional people who live in your home not listed above. Please include names, ages and relationship:		
Who are the significant adult figures in your child's live? (family, coach, teacher, etc.)		
Describe significant changes/transitions in your child's life and the age at which they occurred (divorce, moves, changes in school, death/loss, removal from parent's, etc.)?		
If parents are divorced or separated, what are the current custody and visitation agreements? (You will be asked to provide a copy of the legal documents re: custody & visitation)		

Do any family members (parent, siblings, grandparent, aunts/uncles) struggle with the following?
Learning challenges/disability:
Depression:
Bi-polar:
Alcoholism/Drug addiction:
Trauma (sexual assault, combat, abuse, etc.):
Suicide Attempts:
Eating disorders:
Hyperactivity/ADHD
Psychosis:
Other problems:
Treatment History
Has your child seen a therapist before? Yes _____ No _____
If yes, please rate your previous experiences from 1- 10 (1 being the lowest & 10 highest) :
Name(s) of previous therapist(s):
What helped?
What didn't?
Has your child seen a psychiatrist in the past? Yes__ No __ **Currently? Yes___ No___ If yes, please expain**
Developmental History
Were there any complications with the pregnancy and delivery of your child? **Yes___ No ___ If yes, please explain:**
Describe your child as a baby:
Have you or anyone else had concerns about your child's development? **Yes ___ No ___ If yes, please explain:**

Have you or anyone else had concerns about the intellectual or academic functioning of your child? Yes ___ No___ If yes, please explain
Social and School Functioning
Please describe how your child interacts with other children (including siblings):
Do you have any concerns about your child's functioning in the school environment?
Please describe your child's school performance:
Has your child ever been diagnosed with a learning disability/problem? Yes ___ No ___ If yes please explain
Please list all extracurricular activities that your child participates in:
Cultural and Spiritual History
What should I know about your family to best work with you?
How important is spirituality or religion? Low___ Medium ___ High ___
Does your child or family currently engage in spiritual activities? Yes ___ No ___ If yes, please explain?

Behavior Management
Describe discipline in your home:
Describe how conflict is handled in your home:
What are your expectations of your child?
What areas does your child excel in:
What do you enjoy about parenting?

Thank you for taking time to fill out these form