alight counseling
A PLACE TO FIND HEALING AND REST

2500 Willamette Falls Dr. #105,
West Linn, OR 97068

Child Intake Form **Date of Intake:** _____

Name of Child: _____ **Birthdate:** _____

Preferred Name: _____ **Male/Female/Other:** _____

Guardian(s) Name(s): _____

Is Child (circle)**:** Adopted (is child aware: Y/N) Foster Biological Relative Other:_____

Address: _____ **Apt#:** _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ May I leave a message? Yes No

Work/Cell #: _____ May I leave a message? Yes No

Email Address: _____ May I contact you via email? Yes No

Note: Confidential information will not be shared via email. This is only used for setting and confirming appointments.

Please list all people currently living with child:

Name_____ Relationship_____ Age_____

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Name_____ Relationship_____ Age_____

Parent/guardians marital status:

□Single □Married (legally) □Divorced □Cohabitating □Divorce in process □Separated □Widowed ___Other If Divorced please indicate custody agreement: _____

Length of marriage/relationship:_____ If divorced, how old was your child at time of divorce? _____

If divorced, How much time does your child spend with each parent? Parent 1_____%, Parent 2 _____%

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Parent/Guardian 1 Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship with adolescent, if applicable: Poor_____ Fair_____ Good_____

Parent/Guardian 2 Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship with adolescent, if applicable: Poor_____ Fair_____ Good_____

How did you hear about Me/ or Alight Counseling?

_____

Reason for seeking help at this time?

_____

_____

Please check all your child's behaviors and symptoms that you consider problematic:

❑ Distractibility ❑ Hyperactivity ❑ Impulsivity ❑ Sadness/depression ❑ Hopelessness ❑ Self-harm behaviors ❑ Low self worth ❑ Change in appetite ❑ Anxiety/worry ❑ Isolation ❑ Thoughts of hurting others	❑ Compulsive behavior ❑ Social discomfort ❑ Aggression ❑ Sleep problems ❑ Toileting problems ❑ Lack of motivation ❑ Obsessive thoughts ❑ Boredom ❑ Peer/sibling conflict ❑ Irritability/anger\ ❑	❑ Lying ❑ Nightmares ❑ School/academic problems ❑ Sexual behavior ❑ Fear away from home ❑ Crying spells ❑ Wide mood swings ❑ Poor memory ❑ Fatigue ❑ Other_____ _____ _____

How are these affecting this child?

_____

_____

How are these impacting the relationships with others/family/peers?

_____

_____

How have these concerns evolved over time?

_____

_____

Previous history of counseling? No Yes If yes, when? _____

Who or Where? _____ May I contact them? No Yes

If yes, please provide a phone # or Email: _____

What was child's experience of counseling?

_____

_____

What coping skills have helped?

_____

_____

What have you tried and it was not helped?

_____

_____

What are your child's strengths?

_____

_____

What are your child's challenges?

_____

_____

What are your counseling goals for your child**?**

_____

_____

Child's school: _____

School/ hobbies and/or extracurricular activities child participates in?

_____

Interpersonal/Social/Cultural Information

Please describe your child's social support network (Check all that apply)

- ❑ Family
- ❑ Community Group Please Explain_____
- ❑ Friends
- ❑ Religious/Spiritual Center Please Explain_____

To which cultural or ethnic group does your child belong? _____

What role does this play in their life? _____

Relationships

Parent/Guardian #1:

_____

Parent/Guardian #2::

_____

To Siblings:

_____

To Peers:

_____

To Other Adults:

_____

Developmental History

Pregnancy (Planned/ unplanned/ complications):

_____
_____

Birth/Bonding:

_____
_____

Milestones: Approximate Age

Crawling: _____ Sitting: _____ Walking: _____ Talking: _____

Toilet Training: _____ Feeding: _____ Sleeping: _____

Health History

Allergies: _____

Serious illness/injury: _____

Current Medications: _____

Family History of Illness (mental health or otherwise):

_____
_____
_____

History of trauma to child or family member(s)- Use **C** for Child/ **FM** for Family Member/ **IH** for in Home

❑ Emotional Abuse ❑ Sexual Abuse ❑ Verbal Abuse	❑ Physical Abuse ❑ Illness of loved one ❑ Substance Abuse	❑ Death of loved one ❑ Homelessness ❑ Adoption/Foster Care

Are there any current legal matters at this time? Yes No If Yes please explain:

_____
_____

Life Transitions: Have there been any life transitions in child's life? Such as birth of sibling, divorce, death, Multiple moving house/school, family member no longer in their life…

_____
_____
_____
_____

Is there anything else you would like me to know?

_____
_____
_____
_____