Meagan M. DiVito, Psy.D., P.C.

Child Intake Form

Please provide the following information about your child:

Child's/Patient's Full Name:_____ Date:_____

Nick Name:_____ Birth Date: _____

School and District:_____Grade:_____

Homeroom Teacher:_____

Special Education Student? YES NO Special Education Eligibility:_____

Parent/Legal Guardian:_____

Relationship to Child: _____Age: _____ D.O.B._____

Home Address:
_____ Phone: _____
_____

Business Address:
_____ Phone: _____
_____ Occupation: _____

Additional Parent/ Legal Guardian:_____

Relationship to Child: _____Age: _____ D.O.B._____

Home Address:
_____ Phone: _____
_____
Business Address:
_____ Phone: _____
_____

Marital Status of Parents: Married ____ Divorced _____ Other (explain)_____

Stepmother's Name: _____

Stepfather's Name: _____

Sibling's Name: _____ Age: _____
Check if Half/Step?:_____

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Sibling's Name: _____ Age: _____
Check if Half/Step?:_____

Sibling's Name: _____ Age: _____
Check if Half/Step?:_____

Sibling's Name: _____ Age:_____
Check if Half/Step?:_____

PRESENTING PROBLEM

What brings your child in today?

Please indicate symptoms/behaviors that you find are problematic for your child: (please circle)

Distractibility
Change in appetite
Visual hallucinations
Manipulative behavior
Hyperactivity
Withdrawal from people
Defiance
No/few friends
Impulsivity
Anxiety/worry
Aggression/fights
Eating problems
Boredom
Panic attacks
Homicidal thoughts
Sleep problems
Poor memory/confusion
Fear away from home
Frequent arguments
Nightmares
Sadness/depression
Social discomfort
Irritability/anger
Toileting problems
Fatigue
Lack of motivation
Recurring, disturbing memories
Hopelessness
Phobias
Peer/Sibling conflict
Fire setting
Thoughts of death
Obsessive thoughts
Stealing
Work/School problems
Self-harm behaviors
Compulsive behavior
Destroys property
Legal problems
Crying spells
Racing thoughts
Running away
Sexual behavior
Lonelinesss
Wide mood swings
Swearing
Computer addiction
Low self-worth
Suspicion/paranoia
Curfew violations
Alcohol/drug use
Hearing voices
Lying
Other

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Are your child's problems affecting any of the following? (Please circle)

Handling everyday tasks
Self esteem
Relationships
Hygiene
Work/School
Housing
Legal matters
Finances
Recreational activities
Sexual activity
Health

Has your child ever had thoughts, made statements, or attempted to hurt him/herself? Yes/No If yes, please describe (when and what happened):

Has your child ever had thoughts, made statements, or attempted to hurt someone else? Yes/No If yes, please describe (when and what happened):

Has your child ever been physically hurt or threatened by someone else? Yes/No If yes, please describe (when and what happened):

Behavioral Assets:
What does your child do that you like? What does he /she do that other people like?

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST and how much must they change for you to be satisfied?

FAMILY/DEVELOPMENTAL HISTORY

Please provide the following information about your child:

Who does your child currently live with?

Names	**Ages**	**Relationship to child**

Who are your child's significant others NOT living with your child?

Names	**Ages**	**Relationship to child**

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Family Mental Health	Who?
ADHD	
Autism	
Depression	
Bipolar Disorder	
Suicide	
Anxiety	
Panic Attacks	
OCD	
Developmental Disability	
Learning Disorder	
Sexually Abused	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Substance Abuse	
Other:	

Please circle if your child has experienced any of the following types of trauma or loss:
Emotional abuse
Neglect
Lived in a foster home
Sexual abuse
Violence in the home
Multiple family moves
Physical abuse
Crime victim
Homelessness
Parent substance abuse
Parent illness
Loss of a loved one
Teen pregnancy
Adoption
Financial problems

Please indicate any developmental delays experienced by your child (crawling/walking/talking/etc):

Please indicate any complications during pregnancy:

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

SCHOOL INFORMATION

This year's school grades:
Excellent Good Fair Poor

Past year's school grades:
Excellent Good Fair Poor

This year's school behavior:
Excellent Good Fair Poor

Past year's school behavior:
Excellent Good Fair Poor

Has your child had any of the following difficulties at school? (Please circle)

Suspension	Fighting
Incomplete homework	Lack of Friends
Learning problems	Drug/Alcohol problems
Referrals or detentions	Poor Grades
Teased or picked on	Gang Influence
Speech problems	Attendance problems

Does your child have an after-school provider Yes/No
If so, who?

Has your child ever repeated or skipped a grade? If yes, which one(s)?

MEDICAL HISTORY

What is the name of your child's medical doctor?_____

Address: _____ Phone:_____

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Has your child experienced any of the following medical problems?

A serious accident	Hospitalization	Meningitis
Asthma	A head injury	Surgery
Convulsions/seizures	Eye/ear problems	Other
Hearing problems	Allergies	
Loss of consciousness		

Please list any current medical problems or physical handicaps:

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Reason for Treatment
		Outpatient Counseling		
		Medication (past and current)		

Yes	No	Type of Treatment	When?	Reason for Treatment
		Psychiatric Hospitalization		
		Drug/Alcohol Treatment		
		Self-Help/Support Groups		

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your child's social support network (circle all that apply):
Family
Neighbors
Friends
Co-workers
Support/Self-Help Group
Community Group
Religious/Spiritual Center (which one?) _____

To which cultural or ethnic group does your child belong?

If your child is experiencing any difficulties due to cultural or ethnic issues, please describe:

How important are spiritual matters to your child?
Not at all Little Somewhat Very much

Would you like spiritual/religious beliefs to be incorporated into you or your child's counseling?

LEGAL INFORMATION

If the parents are separated or divorced, what is the current child custody/visitation arrangement?

Is your child currently the subject of a custody case? Yes/No

Has your child ever been a ward of the court with DCFS guardianship? Yes/No

Do you or your child have any legal offenses on record or pending in the courts?