Blue Water Counseling
Intake Assessment Information – Child Form

(Please print all information)

I. CHILD CLIENT — TODAY'S DATE: ______________

A. NAME: ____ BIRTHDATE: ________________

B. What are the concerns about your child for which you are seeking assistance? ______________________

____

____

____

II. FAMILY INFORMATION

A. RACE/CULTURAL INFORMATION

1. Race: __________________

2. Cultural Considerations: ____

B. FAMILY HISTORY OF MENTAL HEALTH OR SUBSTANCE ABUSE PROBLEMS:

[ ] NO [ ] YES Explain: ____

____

____

___

C. CHILD'S PARENTS [ ] Married [ ] Divorced [ ] Separated [ ] Never Married

Birth Father's Name: ____________________ Age: ________ If Deceased, Date: ___________

Occupation: ____________________________ Highest Grade Level: ________________________

Birth Mother's Name: ____________________ Age: ________ If Deceased, Date: ___________

Occupation: ____________________________ Highest Grade Level: ________________________

Step Father's Name: ____________________ Age: ________ If Deceased, Date: ___________

Occupation: ____________________________ Highest Grade Level: ________________________

Step Mother's Name: ____________________ Age: ________ If Deceased, Date: ___________

Occupation: ____________________________ Highest Grade Level: ________________________

Adopted Father's Name: __________________ Age: ________ If Deceased, Date: ___________

Occupation: ____________________________ Highest Grade Level: ________________________

Adopted Mother's Name: __________________ Age: ________ If Deceased, Date: ___________

Occupation: ____________________________ Highest Grade Level: ________________________

D. ANNUAL FAMILY INCOME: [ ] Under $30,000 [ ] $31,000 – $60,000 [ ] $61,000 – $90,000

[ ] $91,000 – $120,000 [ ] $121,000 – $150,000 [ ] Over $151,000

E. LANGUAGE SPOKEN: ____

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F. FAMILY SIZE: _______

G. CLIENT'S BROTHERS AND SISTERS

NAME	AGE	OCCUPATION	EDUCATION	IF DECEASED, DATE & CAUSE	BIOLOGICAL, ADOPTED OR STEP

H. OTHER HOUSEHOLD MEMBERS

NAME	AGE	SEX	OCCUPATION OR GRADE	RELATIONSHIP TO CLIENT

I. RELATIONSHIPS

1. Who does your child live with currently? ______________________________
2. Who did your child live with previously? ______________________________
3. Describe your child's relationship with:

   Parents: ______________________________

   Siblings: ______________________________

   Extended Family Members: ______________________________

   Teacher(s): ______________________________

   Other Children: ______________________________
4. List any family members you wish to have involved in treatment and why : ____________________

III. PHYSICAL DESCRIPTION

A. Child's Height ______________ Weight ______________ Recent Gains or Losses ______________ ___

B. Other distinguishing features: ______________________________

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C. Does your child have any physical impairments or disabilities? If so, explain: ______________________

____

___

D. Are physical characteristics or body image a concern? Explain: ______________________________

____

IV. EDUCATION

A. Name of Current School: ____________________________________ Current grade: ________

B. Name of Teacher: ____________________________ School Social Worker: ______________________

C. Special Education?: [ ] No [ ] Yes If yes, type of Spec Ed certification: __________________

D. [ ] Did not complete school; last school attended: ______________________ Grade Completed: ____

E. Is or was your child's school performance a concern? Explain: ______________________________

____

V. EMPLOYMENT

A. Is your child currently employed? [ ] Yes [ ] No

If yes, [ ] Full time [ ] Part time [ ] Seasonal

B. Name of employer? ____

Comments: ____

VI. SPIRITUAL INFORMATION

A. Is spirituality an area of support or strength for your child? [ ] Yes [ ] No

RELIGION: [ ] Catholic [ ] Jewish [ ] Islamic [ ] Protestant [ ] Other: ______________

B. Is this an area of concern? [ ] No [ ] Yes Explain: ______________________________________

VII. SEXUAL FUNCTIONING

Is this an area of concern? [ ] No [ ] Yes Explain: ______________________________________

____

VIII. COMMUNITY SERVICES RECEIVED CURRENTLY OR PREVIOUSLY

A. MENTAL HEALTH COUNSELING/SUBSTANCE ABUSE TREATMENT

1. Previous Counseling: Where: __________________________ When: ______________________

Where: ______________________________________ When: ______________________

Where: ______________________________________ When: ______________________

2. *Was counseling helpful to your child in the past?* ______________________________________

B. SUPPORT GROUPS

1. List any support groups your child attended in the past or presently: ____________________

____

2. Was support group attendance helpful? ____________________

IX. SUBSTANCE USE

A. Does your child use illegal or unprescribed drugs including alcohol? [ ] No [ ] Yes If yes, explain which drugs, amount and frequency: ____________________

____

B. Does your child misuse prescription drugs? [ ] No [ ] Yes If yes, explain which drugs and how they are misused: ____________________

C. Has anyone ever expressed concern with your child's use of alcohol or other drugs? ____________________

____

D. Does your child smoke cigarettes now? In the past? [ ] No [ ] Yes If yes, explain time period, amount and frequency: ____________________

X. SOCIAL LIFE

A. Describe your family's strengths: ____________________

____

B. Describe your child's support system (ie. family, friends): ____________________

____

C. Describe your child's recreational interests: ____________________

____

D. Describe any relationship problems with friends/peers: ____________________

____

XI. HEALTH HISTORY

A. PRIMARY PHYSICIAN: ____________________

1. Address: ____________________

2. Phone: ____________________ Date of last physical exam: ____________________

B. MEDICATIONS: List all current prescriptions, regularly taken over the counter meds and supplements

____

____

C. Concerns about medications including drug allergies? [ ] No [ ] Yes Explain: ____________________

____

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D. HEALTH PROBLEMS (Check applicable columns):

Problem	*Never*	*Past*	*Present*	*Family History*
Allergies				
Anorexia				
Asthma				
Broken Bones				
Communicable Diseases				
Diabetes				
Fainting/Dizzy				
Hearing Problems				
Heart Disease				
High/Low Blood Pressure				
High/Low Blood Sugar				
Liver Disease, Jaundice				
Major Injuries				
OB/Gyn Problems				
Obesity				
Seizures/Epilepsy				
Stomach or Intestinal Problems				
Thyroid Problems				
Ulcer				
Vision Problems				

Comments: ____

____

____

E. DEVELOPMENTAL ISSUES

List any developmental skills that your child accomplished ahead of or behind others the same age, (examples: walking, talking, reading, etc.): ______________________________________

____

F. NUTRITION

Generally good? [ ] Yes [ ] No Special diet? ______________________________________

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XII. ABUSE HISTORY

Has your child experienced physical, sexual or emotional abuse? [ ] No [ ] Yes Explain: __________

____

XIII. LEGAL HISTORY

A. *Does your child have any history of legal charges? [ ] Yes [ ] No Explain:* ______________________

____

B. *Is your child currently on probation? [ ] Yes [ ] No*

Probation officer's name: ____

C. *Is treatment court ordered?* ____

XIV. DESCRIBE ANY OTHER RELEVANT CONCERNS:

____

____

____

____

____

____

____

____

____

____

____ ____
Signature of Person Completing Form Date *Relationship to Client*

____ ____________________
Signature of Staff Reviewing Credentials *Review Date*