Threshold Counseling and Coaching

Child Intake Form

Today's Date:_____________ Medicaid #: __________________

Name of person completing this form:_________________________ Relationship to child:_______________

Child's Name:____________________________________

Age:________ Date of Birth:__________________ Place of Birth:_______________________

Grade:________________ School:____

Home Address:____

Phone Number:__________________________ Email:____

Emergency Contact:____________________________________ Phone Number:_______________________

Relationship to Child:____________________________________

Name of primary guardian(s):____

Address:____

Phone Number:___________________________ Email:_________________________________

Occupation/Place of Work:____

Background Information

1. Has your child ever participated in therapy before? ___yes ___no
   If yes, when?__________ Reason:__________________________

2. Is your child currently seeing a psychiatrist, therapist, or counselor in addition to myself?
   ____yes ____no If yes, who?____________________

3. Has your child or a family member ever been hospitalized for mental or emotional illness?
   ____yes ____no If yes, please explain (dates, where, reason):
   ____
   ____

4. Has your child ever been diagnosed with a mental health condition or illness? ____yes ___no
   If yes, please explain:____

5. Has your child been previously treated for any mental health issues or illness? ___yes ___no
   If yes, please explain:____

6. Has your child had any surgery, serious illnesses or accidents? ____yes ____no

If yes, please explain:____

7. Does your child have any medical conditions? ___yes ____no
If yes, please explain:____

8. Does your child take any medications regularly? ___Yes ___No
If yes, please list:____

9. Please list your Primary Care Provider:____

10. When was your child's last vision/hearing screening? ____________________________
What were the results?__________________

School and Educational Information

1. Does your child enjoy school? ___yes ___no
2. Does your child receive services for an IEP or 504 plan? ___yes ___no
   If yes, please explain:____
3. Has your child ever had learning difficulties or repeated a grade? ___yes ___no
4. Do you feel your child is making progress at school? ___ yes ___no
5. Does your child have any behavioral issues at school? ___yes ___no
   If yes, please explain:____
6. Do you have any concerns regarding school and your child:
   ____
   ____

Social Emotional Information

1. Please circle any areas of concern for you child:
   Eating Sleeping Nightmares Thumb Sucking

   Bedwetting Getting along with friends Self-help skills

   Understanding Directions Unusual Fears Anger

   Other:______________________________
2. How would you describe your child:
   ____
   ____
3. List your child's interests and hobbies:____

4. Has your child ever experienced any traumatic events (death, accident, illness)?
____
____

Treatment Plan

1. Please tell me in your own words what brings you to counseling today:
____
____
____
____

2. What are your 2 most important goals for your child to accomplish in therapy?
1.____
2.____

Additional information that you would like to add: