



THE RELATIONSHIP CENTER

Branson • Springfield

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“Biblically Christian, Clinically Proven”

CHILD INTAKE FORM

Confidential

Please Print Clearly

Name of Child _____ Birthdate _____ Age _____ Gender: M / F

Address _____ City _____ State _____ Zip _____

School _____ Grade _____ List the persons with whom your child is now living, their age and their relationship to him/her _____

Biological/Adoptive Father (*circle one*) _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____ Phone _____

Occupation _____ Employer _____ Education Level _____

Biological/Adoptive Mother (*circle one*) _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____ Phone _____

Occupation _____ Employer _____ Education Level _____

Step-Father _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____ Phone _____

Occupation _____ Employer _____ Education Level _____

Step-Mother _____ Birthday _____ SS# _____

Address _____ City _____ State _____ Zip _____ Phone _____

Occupation _____ Employer _____ Education Level _____

Adopted? ___ Yes ___ No At what age? _____ Medical/social history of birth parents ___ Known ___ Unknown

Who has legal custody? _____ *** If divorced, please provide a copy of your custody agreement**

Marital status of the biological/adoptive parents of the child (*check all that apply*):

<input type="checkbox"/>	Married	<input type="checkbox"/>	Living Together	<input type="checkbox"/>	Separated	<input type="checkbox"/>	Divorced
<input type="checkbox"/>	Not Married	<input type="checkbox"/>	One Parent Deceased	<input type="checkbox"/>	Father Remarried	<input type="checkbox"/>	Mother Remarried

Please list all of your children, living and deceased, in the order of their birth

Name	Age	Birthdate	Gender	School	Grade in School	Lives at Home?

REFERRAL

How did you find out about us? _____ How did you find our website? _____

Name of referral source _____ Phone _____

If applicable, may we have your permission to confidentially contact this person to thank them for the referral? ____ Yes ____ No

PROBLEM INFORMATION

Briefly describe your primary concern about your child _____

Briefly describe the history and development of your concern from onset to present _____

Why are you coming for counseling now instead of a few months ago or a few months from now? _____

What are your goals for your son or daughter in counseling? _____

What specific anxieties do you have about counseling? _____

Has your child been to counseling before? _____ If so, when? _____ With whom? _____

If so, briefly describe their experience _____

Have your child's report cards or school conferences indicated any special or specific difficulties? _____

What grades has your son/daughter repeated? _____ What special needs and/or learning disabilities does your child have?

DEVELOPMENTAL HISTORY

Mother's health during pregnancy _____ Medication/drugs/alcohol taken (specify) _____

Length of labor _____ Forceps used? ____ Yes ____ No Birth weight _____ Problems/complications before or after delivery? _____

Number of lost pregnancies: _____

At what age did your child accomplish the following?

Sat alone _____ Walked alone _____ Toilet trained _____

Crawled _____ Said words _____ Rode bicycle (2-wheeler) _____

Stood alone _____ Used sentences _____ Was able to read _____

Who, other than the mother, was involved in caring for the child from infancy to five years of age?

PHYSICAL HEALTH

Please list any medical problems, serious illnesses and/or hospitalizations your child has had and the approximate dates:

Date of most recent physical examination _____ Name of primary care physician _____

Please list any medications your son or daughter is currently taking:

Medication	Reason Prescribed	Dose and frequency	Date Started	Prescribing Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Does your son or daughter have a history of or current problem with any of the following areas?

Eating Problems _____ Bed Wetting _____ Masturbation _____ Head Injuries _____

Sleep Difficulties _____ Wetting Pants _____ Runaway _____ Headaches _____

Speech Difficulties _____ Soiling Pants _____ Truancy _____ Temper Tantrums _____

High Fevers _____ Constipation _____ Distractibility _____ Social Withdrawal _____

Has your child ever been neglected and/or abused? If so, please describe: _____

Do any family members have any special medical problems? ____No ____Yes If yes please explain: _____

Please identify any family history of:

	Alcoholism		Retardation		Learning Problems
	Drug Abuse		Emotional Problems		Over-activity
	Suicide		Marital Problems		Bi-polar Disorder
	Suicide Attempts		Depression		Physical or Sexual Abuse
	Occult/Witchcraft		Schizophrenias		Imprisonment

Check any of the following which definitely describe your son or daughter:

- | | | | |
|--|---------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Selfish | <input type="checkbox"/> Doesn't Care | <input type="checkbox"/> Obedient | <input type="checkbox"/> Resentful |
| <input type="checkbox"/> Spoiled | <input type="checkbox"/> Unmotivated | <input type="checkbox"/> Industrious | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Moody | <input type="checkbox"/> Depressed | <input type="checkbox"/> Easily Led | <input type="checkbox"/> Violent |
| <input type="checkbox"/> Vain | <input type="checkbox"/> Defiant | <input type="checkbox"/> Forgiving | <input type="checkbox"/> Sensitive |
| <input type="checkbox"/> Clean | <input type="checkbox"/> Dramatic | <input type="checkbox"/> Emotional | <input type="checkbox"/> Awkward |
| <input type="checkbox"/> Kind | <input type="checkbox"/> Flirtatious | <input type="checkbox"/> Inadequate | <input type="checkbox"/> Untidy |
| <input type="checkbox"/> Sweet | <input type="checkbox"/> Compliant | <input type="checkbox"/> Adaptable | <input type="checkbox"/> Polite |
| <input type="checkbox"/> Unfocused | <input type="checkbox"/> Teachable | <input type="checkbox"/> Silliness | <input type="checkbox"/> Thoughtful |
| <input type="checkbox"/> Sexual Concerns | <input type="checkbox"/> Vengeful | <input type="checkbox"/> Unruly | <input type="checkbox"/> Opinionated |
| <input type="checkbox"/> Sassy | <input type="checkbox"/> Reclusive | <input type="checkbox"/> Untruthful | |
| <input type="checkbox"/> Resents Authority | <input type="checkbox"/> Ill-tempered | <input type="checkbox"/> Disobedient | |
| <input type="checkbox"/> Quarrelsome | <input type="checkbox"/> Considerate | <input type="checkbox"/> Fearful | |

What does your child enjoy doing for fun? _____

What extra-curricular activities is your child involved in? _____

Date and place of last vacation: _____

As parent and/or legal guardian, of the daughter/son described above, do you give permission for him/her to engage in counseling and/or assessment at Tri-Lakes Relational Center? _____

Is the information you have provided on this form true and accurate? _____

Signature: _____

Date: _____