Peace of Mind Counseling

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Child Intake Form

Childs Name_________________________ D.O.B____________________ Age:_______

School:_____________________________ Phone:______________________

Teacher:____________________________ Grade:_________

How does your child perform academically?
____

How does your child act in school behaviorally?_______________________________________

Does your child have a learning or physical disability? Y___ N__ Maybe____
Specify_______________________________________

Does your child have a mental health diagnosis? Y__N__ If yes please
specify____

Is your child currently taking any prescription medication? __________________________

For what purpose?____

Does your family have any specific beliefs?_______________________________________

Are parents separated/divorced?__________________________ How long?___________

How do you discipline?_______________________________________

Who lives in the household?___________________________________

Anyone in the family struggled with depression or suicidal ideation?______________________

How do you and your child handle stress?____

What are your child's sleeping habits?____

Has there been any physical, emotional, or sexual abuse to your child that you are aware of?
____

What are your child's strengths?____

What are your child's weaknesses?
____

What would you and your child like to accomplish in counseling?
____

Medical History

During pregnancy, did mother use:___cigarettes,____Alcohol_____Drugs,___experience extreme stress?

Specify frequency, duration, and amounts:_____________________________________

List any birth complications (Ex: Premature, jaundice, C-section, etc.)

____

List medical conditions or history (Ex: Surgeries, broken bones, allergies)

____

Does child use:___cigarettes___Alcohol____Drugs

Specify frequency, duration, and amounts:_____________________________________

Primary Care Physician_______________________Phone_____________Last seen______

Current Medications (please include dosage and frequency)

____

Medication Allergies:____

Other Allergies____

Family Information

Name	Age	Relationship