Wellbeing Counseling

Wellbeing Counseling/2024 82nd St., Suite 101
Lubbock, TX 79423/806-853-6540

Child Intake Form

CLIENT INFORMATION

Today's Date ___/___/___ Referred By _____

Child's Name _____ Age _____

Preferred Name _____ DOB ___/___/___

Child's Legal Guardian(s) _____

Parent(s) ☐ Biological ☐ Adoptive ☐ Foster ☐ Other

Caregiver/Parent Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Civil Union

Child's Address _____

_____

Guardian Address _____

_____

Home Phone ( ) _____-_____

Cell Phone ( ) _____-_____

Work Phone ( ) _____-_____

Other Phone ( ) _____-_____

Preferred Email _____

Emergency Contact _____

BASIC INFORMATION

What concern has caused you to bring your child into counseling at this time?

_____

_____

_____

_____

_____

_____

_____

EDUCATION

School Attended _____

Grade level in school _____

Typical grades earned _____

Intellectual Concerns _____

Behavioral Concerns _____

IEP or 504 _____

Extracurricular activities _____

SYMPTOMS CHECKLIST

Sleep Issues	Developmental Delays	Hostile
Mood Swings	Unhappy	Physical Aggressive
Provokes Others	Unmotivated	Self-Injurious
Anxious	Wets Bed	Head Banging
Easily Agitated	Fearful	Hair Pulling
Breaks Law	Negative Attitude	Skin Picking
Bullied	Eating Issues	Fire Setting
Bullies Others	Frequently Sick	Mute
Worries A lot	Defiant	Isolates
Cries Frequently	Lies Often	Speech Problems
Stealing	Lethargic	Shy
Conflicts at Home	Conflicts at School	Learning Differences
Tantrums	Substance Misuse	Hyperactive
Elimination Issues	Tics	Sexually Inappropriate

PERSONAL INFORMATION

Describe your child's personality.

_____

_____

_____

_____

_____

What are your child's strengths ? _____

_____

_____

_____

_____

_____

_____

What are your child's needs and struggles? _____

_____

_____

_____

_____

_____

Has your child been in counseling/therapy before? Yes No

Counselor's name and dates seen:

_____

_____

Outcome & Diagnosis (if any):

_____

_____

_____

Has your child been seen by a psychiatrist? Yes No

Psychiatrist's name and dates seen:

_____

_____

_____

Has your child experienced any traumas? Yes No

Please describe any traumatic experiences below. Please add dates (if possible) and if there's any state or legal involvement:

_____

_____

_____

_____

_____

Has your child misused substances (tobacco/alcohol/ prescription medications/street drugs) or displayed addictive behaviors (including video gaming)? Yes No

If so, please describe:

_____

_____

_____

Has your child displayed self-harming behavior or suicidal behavior? Yes No

If so, please describe. If actual suicide attempts, provide date(s):

_____

_____

_____

_____

Has your child had any legal issues (police or school resource officers, juvenile system)? Yes No

If so, please describe:

_____

_____

_____

Any abuse/mistreatment to pets or animals? Yes No

If so, please describe:

_____

_____

_____

_____

How would you rate the intensity of the struggle/concern that brought you and your child into counseling?

1 2 3 4 5

Little Somewhat Extremely

How long has your child experienced this struggle/concern?

_____

In what ways have you attempted to cope? _____

_____

_____

_____

If applicable, how have the rest of the individuals in the household coped?

_____

_____

_____

_____

Does your child appear aware of the concern/struggle, and if so, does your child communicate with you or any other caregiver in the home about it?

_____

_____

_____

_____

FAMILY COMPOSITION

Who currently resides in the home with the child?

(Name, Age, Relation)

_____

_____

_____

_____

_____

Any pets in the home?

_____

Describe your child's relationships with the other individuals in the home. Is there a particular individual your child is closest to? Furthest from?

_____

_____

_____

_____

_____

If there is more than one caregiver/parent in the child's home, how do those individuals relate to each other? Any relationship struggles?

_____

_____

_____

_____

How would you describe the parenting style in the child's home? If there is more than one caregiver/parent in the child's home, are the parenting styles the same or different?

_____

_____

_____

_____

Check any current or past family issues:

☐ Divorce ☐ Separation ☐ Financial stress

☐ Serious/chronic medical illness ☐ Mental illness

☐ Substance misuse/abuse ☐Legal problems

☐ Parental/caregiver incarceration ☐ Domestic violence

☐ Motor vehicle accident ☐ Relocation/move

☐ Sexual trauma ☐ Death of a loved one

☐ CPS involvement ☐ Parent/caregiver job loss

☐ Gambling problems or other addictive behaviors

☐ Other

_____

_____

_____

_____

MEDICAL INFORMATION

Please rate your child's overall physical health:

Excellent Good Fair Poor

Does your child have any chronic medical issues? Yes No

If so, please describe:

_____

_____

_____

Do you feel your child gets enough sleep? Yes No

If not, please describe:

_____

_____

Is your child eating restricted in any way (due to illness or allergies, or other)? Yes No

If so, please describe:

_____

_____

What kind (and how much) physical activity does your child get?

_____

_____

How much caffeine does your child consume daily?

_____

Is your child on any medication? Yes No

If so, please list (including daily OTC medications and any vitamins or supplements):

_____

_____

_____

_____

_____

Any other health concerns regarding your child?

_____

_____

SOCIAL INFORMATION

How would you describe your child's social life? Any close friendships?

_____

_____

_____

Does your child interact well with other peers close to their age? With others in a different age range?

_____

_____

_____

Are there any particular social behaviors that concern you?

If yes, please describe:

_____

_____

_____

Are you aware if your child is experiencing bullying (school, home, or elsewhere)? If so, please describe:

_____

_____

Are you aware if your child identifies as a different gender, other than their birth-assigned gender? Yes No

If so, please describe:

_____

_____

Are you aware if your child is experiencing any struggles with their sexual identity or sexuality? Yes No

If so, please describe:

_____

_____

Are there religious affiliations, guidelines or beliefs you feel the counselor needs to be aware of?

_____

_____

Does your child have any hobbies? Yes No

If so, please describe:

_____

_____

_____

Does your child participate in any extra-curricular activities? Yes No

If so, please list/describe:

_____

_____

_____

How does your child spend most of their leisure time?

_____

_____

_____

OTHER INFORMATION

Are there any other concerns or issues you feel the counselor should be aware of? If so, please describe:

_____

_____

_____

_____

What is your wish/desired outcome for your child and their future?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please let us know how you found us?

☐ Referral ☐ Internet ☐ Other

_____

_____

_____

Thank you for taking the time to fill out this intake. It is of the utmost importance to us that we learn about your child and the concerns that lead you to bring them in to our practice!