Phoenix Counseling Group & Play Therapy Center, LLC

Childhood History / Self-Intake

(*As reported by the client, parent, or legal guardian*)

Child's Name _____ Date_____

Date of Birth _____ Age_____ Gender _____

Adopted ___ yes ___ no Is your child aware of adoption? ___ yes ___ no

Names of others in Household:	Relationship to child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are the parents of the child married or divorced? _____

If parents are divorced, please indicate the visitation schedule:

Please provide the name, address and phone number for the noncustodial parent:

Name: _____ Phone # _____

Address:_____

Briefly state your main concerns about your child: (Please not the specific concerns, duration of the problem, frequency and intensity of the problems as well as what you have done to address the issue)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have any of the child's blood relatives experienced similar problems?

Did the child's mother or the child experience any complications during pregnancy/delivery?

MEDICAL HISTORY Please note the age and any other pertinent information. Use back if necessary.

Childhood diseases: _____
Operations: _____
Other hospitalizations: _____
Head injuries:_____
Convulsions/seizures: _____
Persistent high fevers: _____
Eye problems: _____
Tics (eye blinking, sniffing, or any repetitive movement): _____
Ear problems: _____
Allergies or asthma: _____
Sleep problems (restless, night waking, sleepwalking): _____
Bedwetting or soiling pants in daytime: _____
Describe the child's appetite: _____
Please list other doctors or professionals consulted: _____
Current medications and dose: _____
Counseling: _____

FAMILY/SOCIAL HISTORY

Please indicate if the is a history any of the following issues for family members as applicable (Be sure to include PAST or PRESENT issues): depression, anxiety/excessive worrying, alcoholism, drug addiction/usage, abuse (indicate physical, verbal and/or sexual abuse and by whom or to whom), rape, miscarriages, bi-polar disorder, schizophrenia, mental health hospitalizations (indicate reason), anorexia, bulimia, ADHD/ADD, criminal activity, parental divorce. Please indicate which of the following family members is deceased, at what age the family member died and year of death.

Birth Mother Childhood/Adult History:_____

_____

Birth Father Childhood/Adult History: _____

_____

Step-Mother Childhood/Adult History: _____

_____

Please indicate which of the family members listed below have a history of the following (Please include past and present issues): depression, anxiety/excessive worrying, alcoholism, drug addiction/usage, abuse (indicate physical, verbal and/or sexual abuse and by whom or to whom), rape, miscarriages, bi-polar disorder, schizophrenia, mental health hospitalizations (indicate reason), anorexia, bulimia, ADHD/ADD, criminal activity, parental divorce. Please indicate which of the following family members is deceased, at what age the family member died and year of death.

Step-Father Childhood/Adult History:

_____

_____

Adopted Mother Childhood/Adult History:

_____

_____

Adopted Father Childhood/Adult History:

_____

_____

Paternal family members:

Client's grandfather and/or step grandfather:

_____

_____

Client's grandmother and/or step grandmother:

_____

_____

Client's aunt(s) (Please indicate names):

_____

_____

_____

Client's uncle(s) (Please indicate names):

_____

_____

_____

Client's cousins (Please indicate names):

_____

_____

Please indicate which of the family members listed below have a history of the following (Please include past and present issues): depression, anxiety/excessive worrying, alcoholism, drug addiction/usage, abuse (indicate physical, verbal and/or sexual abuse and by whom or to whom), rape, miscarriages, bi-polar disorder, schizophrenia, mental health hospitalizations (indicate reason), anorexia, bulimia, ADHD/ADD, criminal activity, parental divorce. Please indicate which of the following family members is deceased, at what age the family member died and year of death.

Maternal family members:

Client's grandfather and/or step grandfather:

_____

_____

Client's grandmother and/or step grandmother:

_____

_____

Client's aunt(s) (Please indicate names):

_____

_____

_____

Client's uncle(s) (Please indicate names):

_____

_____

_____

Client's cousins (Please indicate names):

_____

_____

_____

Which family member(s) has the best relationship with the patient?

_____

_____

INFANCY - TODDLERHOOD

Were any of the following present during the first few years?

_____ did not enjoy cuddling
_____ difficult to comfort
_____ excessive restlessness
_____ frequent head banging
_____ was not calmed by being held
_____ colic
_____ excessive irritability
_____ constantly into everything

TEMPERAMENT: please rate the following as you child appeared in infancy and toddlerhood:

Activity level: _____ underactive _____ average activity level _____ overactive
Adaptability: _____ adapted easily to change _____ resisted change
Intensity: _____ average _____ feelings were often intense
Mood: _____ often happy _____ average range of moods
_____ often dissatisfied or irritable

DEVELOPMENTAL MILESTONES

As best you can recall, list age of development, or check item at right:

	Age	or	Early	Normal	Late
Walked without assistance	_____		_____	_____	_____
Spoke first words	_____		_____	_____	_____
Toilet trained daytime	_____		_____	_____	_____
Toilet trained nighttime	_____		_____	_____	_____

Any speech/articulation problems?

COORDINATION Rate your child on the following skills:

	Good	Average	Poor
Walking	_____	_____	_____
Running	_____	_____	_____
Throwing	_____	_____	_____
Catching	_____	_____	_____
Shoelace tying	_____	_____	_____
Writing	_____	_____	_____
Athletic abilities	_____	_____	_____

COMPREHENSION AND UNDERSTANDING

How well do you consider your child to understand directions and situations in relation to how well other children his/her age do?

How would you rate your child's overall level of intelligence?

_____ Below average _____ Above average _____ Average

PEER RELATIONSHIPS

How does your child get along with others his/her age? Describe any problems.

DOES YOUR CHILD HAVE A HISTORY OF SENSORY PROCESSING PROBLEMS? (i.e.- significant problems with tolerating loud noises, such as vacuum or hair dryer; picky eater due to taste, texture or smell of food, difficulty tolerating tags on clothes)

How well does your child transition between activities, “shift gears”, tolerate new people or new routines now or in the past?

SCHOOL HISTORY

School currently attending: _____ Grade level _____

Is you child in any resource or special classes? _____

Has your child ever repeated a grade? If so, which and why? _____

Briefly describe your child’s school progress. Note usual grades, any problems or successes, strong subjects and weak subjects:

Preschool – K

_____

_____

_____1st - 5th

_____

_____

_____

6th - 8th

_____

_____

_____

9th - 12th

_____

_____

_____

Describe any conduct problems you child has had in school:

How would you rate your child’s homework/study skills? ___ Good ___ Average ___ Poor

Describe difficulties: _____

_____

Has your child had tutoring or remedial work? _____

_____

Does your child like to read? _____ How often (circle one) Never Seldom Occas. Often

Please rate reading ability as _____ good _____ fair _____ poor

Any other comments on your child’s performance and behavior:

HOME BEHAVIOR AND MOOD

Check which of the following applies to your child:

_____ frequently irritable or moody
_____ can't seem to enjoy doing anything
_____ sad spells
_____ crying spells
_____ easily bored
_____ poor or low motivation
_____ low self-esteem (makes negative statements about self)
_____ can't seem to concentrate
_____ has had thoughts of or made comments about suicide
_____ other: _____
_____ eats (too much) or (too little)
_____ frequent arguing at home
_____ fearfulness
_____ nervous, anxious
_____ frequent headaches
_____ frequent stomachaches
_____ has had a panic attack (rapid heartbeat, sweaty palms, feeling something bad about to happen)
_____ difficulty sleeping:
___ goes to sleep very late
___ hard to get up in morning
___ very restless sleep
___ bad dreams
_____ acts like driven by a motor
_____ doesn't seem to learn from experience
_____ very disorganized (loses things, has very messy room)
_____ has ever been physically or sexually abused
_____ drug or tobacco use: _____
_____ argues with or rude to teachers

If your child experienced any stressful or traumatic situations in the past few months or in the last few years please describe:

Any additional comments you would like to make about your child (mood, behavior, personality, etc.):