Centered: NorthShore Center for Mental Health

114 Kedzie Street, Suite 1 Evanston, IL 60202 847.334.3478

Biographical Information – New *Child* Client Intake Form

Please fill out this biographical background form as completely and openly as possible for each child in therapy. It will help me in our work together. Information is confidential as outlined in the Information for Client document. If certain questions do not apply to the child, leave them blank. There is no need to duplicate information. Please bring this with you to the first session.

Child's Personal History

Information supplied by: ____

Relationship: ______________________________________ Date: ____________________

Child's name: ______________________________________ Date of Birth: ___________

Age: ____________ Gender: ________M ______F Weight: ________ Height: __________

Eye color: ____________________ Hair color: __________________ Race: ______________

Address: ____

City: __________________________________ State: ______ Zip: ____________________

Home phone: _______________________ Alternate phone: __________________________

Mother's cell: _______________________ Father's cell: ______________________________

Email address: ____

Year in school: ______________________ Teacher's name: ___________________________

Why is the child coming to therapy?

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Describe the progression of your child's problem or behavior (When did it begin, how long has it lasted? How have you reacted? What have you tried so far?)

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Under what conditions do the problems usually get worse?

____

Under what conditions are the problems usually improved?

Describe your child's positive attributes and strengths.

Describe your hopes for bringing your child and family to therapy.

Child's Prenatal Period, Infancy and Early Childhood

(Please feel free to use a separate page where necessary.)

Did the child's mother have any occurrence of miscarriage or a stillbirth? __ Yes __ No
If yes, describe:

Was the pregnancy with this child planned? __ Yes __ No
Length of pregnancy: ____
Mother's age at child's birth: _______ Father's age at child's birth: _______
Child number ___ of ___ total children
How many pounds did the mother gain during the pregnancy? _______________
While pregnant did the mother smoke? ___ Yes __ No
If yes, what amount: __________
Did the mother use drugs or alcohol? ___ Yes __ No
If yes, type/amount: ___________
While pregnant, did the mother have any medical or emotional problems or stress?

Describe your child's first three years of life. Please include the following:
Quality of prenatal care, birth and postnatal care

Was the baby breastfed? For how long? Describe weaning.

____
____
____
____

Did mother suffer postpartum depression or anxiety? ___ Yes ___ No

How did the baby respond to holding, eye contact, and nurturance?

____
____
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____

What kinds of emotional support were available for the mother and father during the child's early years?

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____
____
____

Who cared for the child during his/her first 3 years?

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____
____
____

How were limits set for your young child?

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____
____
____

If your child was adopted, please indicate details of the adoption and what is known of your child's early history (i.e., domestic or international adoption, agency name, foster-placement history, degree of openness in adoption, what is known of birth family, prenatal and birth history).

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____
____

Medical History

Name and address of child's primary physician:
Physician's name:

____

Address: ____
City: ________________________________ State: __________ Zip: ________________
Date of most recent physical exam: ____
Results: ____

Dental

Date of most recent exam: ____

Results: ____

Vision

Date of most recent exam: ____

Results: ____

Hearing

Date of most recent exam: ____

Results: ____

Psychiatric treatment

Name of Physician: ____

Dates of treatment: ____

Describe previous psychotherapy your child and/or family has had, duration, and results.

____

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____

Current prescribed medications	Dose	Dates	Purpose	Side effects
____________	_____	_____	_______	__________
____________	_____	_____	_______	__________
____________	_____	_____	_______	__________
____________	_____	_____	_______	__________

Current vitamins or supplements	Dose	Dates	Purpose	Side effects
____________	_____	_____	_______	__________
____________	_____	_____	_______	__________
____________	_____	_____	_______	__________
____________	_____	_____	_______	__________

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
____________	_____	_____	_______	__________
____________	_____	_____	_______	__________
____________	_____	_____	_______	__________

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio
2 months	____	_____
4 months	____	_____
6 months	____	_____
18 months	____	_____
4-5 years	____	_____

15 months ___ MMR (Measles, Mumps, Rubella)

24 months ____ HBPV (Hib)

prior to school _____ HepB

Please check if child has history of any of the following:

Abortion	Hay fever	Pneumonia

__Asthma	__ Heart trouble	__Polio
__Blackouts	__ Hepatitis	__ Pregnancy
__ Bronchitis	__ Hives	__ Rheumatic Fever
__ Cerebral Palsy	__ Influenza	__ Scarlet Fever
__ Chicken Pox	__ Lead poisoning	__ Seizures
__ congenital problems	__ Measles	__ severe colds
__ Croup	__ Meningitis	__ severe head injury
__ Diabetes	__ Miscarriage	__ sexually transmitted disease
__ Diphtheria	__ Multiple sclerosis	__ Thyroid disorders
__ Dizziness	__ Mumps	__ Vision problems
__ Ear infections	__ Muscular Dystrophy	__ Wearing glasses
__ Eczema	__ Nose bleeds	__ Whooping cough
__ Encephalitis	__ other skin rashes	__ Fevers
__ Pleurisy	__ Paralysis	__ other

List any major illnesses and/or operations with dates:

____
____
____
____

Describe any medical problems your child has experienced: (e.g. inner ear problems, colic, hospitalizations, premature birth, lack of prenatal care, etc.)

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____
____

List any physical concerns occurring at present:

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____
____
____

List any physical concerns, accidents or traumas experienced in the past:

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On average how many hours does the child sleep daily?

____

Does the child have trouble falling asleep at night? ___Yes ___No
If yes, how long has this been a problem?

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____
____
____

Describe the child's appetite and typical daily meals (during the past week):

Does the child/adolescent use or have a problem with alcohol, drugs or pornography? __Yes __ No

If yes, describe:

Has the child ever been diagnosed with an eating disorder? ___ Yes ___ No

If yes, describe:

Family History

With whom does the child live at this time?

Is the child adopted or raised with parents other than biological parents? ___ Yes ___ No

Are parents divorced or separated? ___

If parents separated or divorced, how old was the child then? ___

If yes, who has legal custody? ___

Were the child's parents ever married? ___ Yes ___ No

What significant information about the parents' relationship or treatment toward the child might be beneficial in therapy?

What is the family relationship between the child and his/her custodial parents?

___ Single parent mother ___ Single parent father ___ Parents unmarried

___ Parent's married, together ___ Parents divorced ___ Parents separated

___ With mother and stepfather ___ With father and stepmother

___ Child adopted ___ other, describe

Is there a history of recent occurrence(s) of child abuse to this child? __ Yes __ No

If yes, which type(s) of abuse? __ Verbal __ Physical __ Sexual __ Emotional

Comments:

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Child's Mother

Name: ____ Age:_______

Occupation: _______________________FT___PT__

Where employed: ____Work phone:_______________

Mother's highest level of education:

____

____

____

____

Is the child currently living with mother? ___ Yes ___ No

Is there anything notable, unusual or stressful about the child's relationship with the mother?

___ Yes __ No If yes, please explain:

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____

How is the child disciplined by the mother?

____

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____

For what reasons is the child disciplined by the mother?

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Child's Father

Name: ____ Age: _______

Occupation: ____ ___FT ___PT

Where employed: ____Work phone: ___________________

Father's highest level of education:

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Is the child currently living with father? ___ Yes ___ No

Is there anything notable, unusual or stressful about the child's relationship with the father?

___ Yes __ No If yes, please explain:

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How is the child disciplined by the father?

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____
____
____

For what reasons is the child disciplined by the father?

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Child's Siblings and Others who live in the Household

(Please indicate names, ages, and quality of relationship.)

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____
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____
____
____
____

Briefly describe the child's relationship with brothers and/or sisters:
Birth siblings:

____
____
____
____

Step and/ or half siblings:

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____
____
____

Other:

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____
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____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (Parents, siblings, aunts, uncles or grandparents) Check those which apply:

__ Allergies	__ Deafness	__ Muscular Dystrophy
__ Alcoholism	__ Diabetes	__ Nervousness
__ Asthma	__ Glandular problems	__ Perceptual motor disor

__ bleeding tendency	__ Heart disease	__ Mental Retardation
__ Blindness	__ High blood pressure	__ Seizures
__ Cancer	__ Kidney disease	__ Spinal Bifida
__ Cerebral Palsy	__ Mental illness	__ Suicide
__ Cleft lips	__ Migraines	__ other (specify):
__ Cleft palate	__ Multiple sclerosis	____________________

Comments:

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CLIENT NAME____

I, ____THE UNDERSIGNED HEREBY ATTEST THAT I HAVE VOLUNTARILY ENTERED INTO TREATMENT WITH THE STAFF OF CENTERED: NORTHSHORE CENTER OF MENTAL HEALTH. FURTHER, I CONSENT TO HAVE TREATMENT PROVIDED THE THERAPISTS AT CENTERED: NORTHSHORE CENTER OF MENTAL HEALTH. I UNDERSTAND THAT THERAPY MAY BE DISCONTINUED AT ANY TIME BY EITHER PARTY; HOWEVER, WE RECOMMEND THAT THIS DECISION BE DISCUSSED WITH YOUR PSYCHOTHERAPIST AND MADE AS A JOINT DECISION WHENEVER POSSIBLE. THIS COOPERATION WILL FACILITATE BETTER DISCHARGE PLANNING AND RE-ENTRY INTO THE PROGRAM SHOULD IT BE NEEDED AGAIN AT A LATER DATE.

IF THE CHILD IS A MINOR, PARENT OR GUARDIAN SIGNATURE:____

PRINT SIGNATURE:____