COMPREHENSIVE CONFIDENTIAL INTAKE FOR KIDS

IF THERE IS INSUFFICIENT SPACE, PLEASE FEEL FREE TO USE THE BACK SIDE OF THE FORM OR ADD ADDITIONAL PAGES AS NEEDED. WE REALIZE INFO IS REPLICATIVE FOR PARENT INTAKES – THERE ARE LEGAL AND PROTECTIVE REASONS WE KEEP DOCUMENTS SEPARATE, SO BEAR WITH US AND COMPLETE THE FORM IN ITS ENTIRETY.

Name:_____ Date: _____

Address:_____ Grade: _____

City/State/Zip:_____ Home Phone: _____

Email: _____ Cell Phone: _____

☐ Male ☐ Female ☐ Trans/IS Birth Date:_____ Age: _____

☐ Heterosexual ☐ Homosexual/Lesbian ☐ Bisexual ☐ Other ☐ Undetermined

☐ Presumed ☐ Expressed _____

Condition Checklist: Physical issues can directly impact psychological functioning and vice versa. The first language of a child is somatic (the body), so children often express emotional distress through their bodies. Please check the conditions that apply to your child now or in the past and add your comments below.

Musculo-Skeletal
- ❑ Headaches
- ❑ Muscle tension
- ❑ Joint stiffness/swelling/pain
- ❑ Spasms/cramps
- ❑ Strains/sprains
- ❑ Back/hip pain
- ❑ Shoulder/neck pain
- ❑ Arm/hand pain
- ❑ Leg/foot pain
- ❑ Chest/ribs/abdominal pain
- ❑ Jaw pain/TMJ
- ❑ Scoliosis
- ❑ Bone/joint disease
- ❑ Other_____

Digestive/Urinary
- ❑ Indigestion
- ❑ Constipation - Chronic
- ❑ Intestinal gas/bloating
- ❑ Diarrhea - Chronic
- ❑ Diverticulitis or Colitis
- ❑ Irritable bowel syndrome
- ❑ Crohn's disease
- ❑ Interstitial cystitis
- ❑ Other: _____

Skin
- ❑ Rashes
- ❑ Allergies
- ❑ Eczema
- ❑ Acne
- ❑ Other_____

Circulatory and Respiratory
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Cold feet or hands
- ❑ Cold sweats
- ❑ Swollen ankles
- ❑ Varicose veins / Blood clots
- ❑ Heart condition
- ❑ Allergies
- ❑ Sinus problems
- ❑ Asthma
- ❑ Low or High blood pressure
- ❑ Lymphedema
- ❑ Other_____

Sexual
- ❑ Gender dysphoria
- ❑ Genital Pain/Itching
- ❑ Other _____

Nervous System
- ❑ Numbness/tingling
- ❑ Fatigue
- ❑ Chronic pain
- ❑ Sleep disorders
- ❑ Ulcers
- ❑ Paralysis
- ❑ Cerebral palsy
- ❑ Epilepsy
- ❑ Multiple sclerosis
- ❑ Muscular dystrophy
- ❑ Spinal cord injury
- ❑ Other_____

Other
- ❑ Surgeries
- ❑ Diabetes
- ❑ Pernicious Anemia
- ❑ Sickle Cell Anemia
- ❑ Cancer
- ❑ Hypothyroid
- ❑ Hyperthyroid
- ❑ HIV/AIDS/Infectious Condition
- ❑ Visually impaired
- ❑ Hearing impaired
- ❑ Other _____

CLIENT NAME:

Comments for any check boxes on previous page:

Symptom Checklist: Please check any symptoms your child has expressed or that you believe they experience.

	Now	During Past Year		Now	During Past Year
Sadness			Explosive Temper		
Loss of interest			Mood swings		
Hopelessness			Nervous		
Boredom			Excessive Worry		
Loss of appetite			Impatient		
Weight loss			Panicky		
Weight gain			Dry mouth		
Low energy			Bowel problems		
Cry easily			Hyperventilation		
Poor concentration			Faintness/dizziness		
Forgetfulness			Pounding heart		
Difficulty falling asleep			Obsessive thoughts		
Sleeping too much			Trembling		
Waking up early			Sweating		
Restlessness			Chocking sensations		
Irritability			Nausea		
Expresses wanting to die			Chest pain		
No desire to live			Undifferentiated fear		
Feel worse in the AM			Anxiety or fear of:		
No need for sleep			Crowds, school, people		
Talking too much too			Natural events (weather)		
Impulsivity			Bad people, evil, supernatural		
Racing thoughts			Death, bodily injury		
Excessively apologetic			Being left alone/in dark		
Preoccupation with sex			Animals		
Sexually overactive			High places		
Uncontrollable urges			Other		

Say more about anything you've checked:

Please list the names of all people living in your child's household and their relationship to your child. Specify if your child lives between several households or spends significant time at other's houses (e.g. grandparents).

Legal Guardian 1: _____

Legal Guardian 2: _____

What is your child's racial/ethnic/cultural background? _____

How is faith/religion/spirituality practiced in your family? _____

What are the general concerns you have about your child? _____

Does your child show any concerning behaviors about or express any discomfort with their body? _____

On average, how many hours per night does your child sleep? _____

How would you describe your child's eating habits? _____

Sugar Intake: _____ Processed Food? _____ Caffeine: _____

Chemical Dependency / Abuse / Addiction

Has your child shown any indication of chemical dependency/abuse? If yes, please describe _____

_____

Does your child have any interests that seem addictive (electronics, puzzles, porn, etc) _____

_____

Medications:

Current non-prescription medications, supplements & vitamins _____

_____

Current prescription medications (include doses)_____

_____

Previous/Discontinued prescription medications (include doses)_____

_____

Other Medical:

Current Physicians	Type of Care/Treatment for
	Primary Health Care Provider

When was the last time your child had a full physical evaluation? _____

Was a blood panel done at that time? ☐ Yes ☐ No results? _____

Other medical history that hasn't been noted: _____

_____

_____

_____

Mental Health History: Has your child been diagnosed with any mental condition or biochemical imbalance?

_____

_____

Does your child have a history of physical, sexual, verbal or emotional abuse, including bullying? Please describe:

Has your child ever attempted suicide? If so, please provide more info (e.g. number of attempts, age, circumstances)

History of Mental Health Treatment – Inpatient

Date	Hospital	Reason for Admission	Length of Stay

Total number of psychiatric hospitalizations: _____

History of Mental Health Treatment – Outpatient

Date	Who / Where	Reason for Seeking Services	Outcome or Benefit

Current Mental Health Providers **Type of Care**

I certify that the responses are correct to the best of my knowledge. I agree to inform my clinician should my physical or mental condition change. I am the parent/legal guardian of this child and with full legal authority to consent to treatment. I give permission for Sabrina Santa Clara, LCPC, to provide treatment for this child which may include assessment, advocacy, referral and mental health counseling.

Client Signature Date

Parent/Guardian Signature Date