



Lake Country Associates
515 Bridge Street East * Park Rapids, MN 56470

CHILD INTAKE FORM

Today's Date: _____

GENERAL INFORMATION Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Child's Name: _____ Child's age: _____ Date of Birth (DOB): _____

Mailing Address: _____

Physical Address: _____

Race: White Black/African American Asian Native Hawaiian/Pacific Islander Hispanic/Latino
 American Indian/Alaska Native Tribe: _____

Bio Parent's Name: _____ Bio Parent's Name: _____

Emergency Contact: _____ Phone # _____

"I authorize Lake Country Associates, Inc. to release necessary information to my emergency contact in the event of an emergency."

Home phone: _____

May I leave a message? Yes No

Cell phone: _____

May I leave a message? Yes No

Work phone: _____

May I leave a message? Yes No

Email: _____

May I email you? Yes No

(For appointment scheduling purposes only, as email not considered a confidential medium of communication).

Was your child referred to Lake Country Associates? Please provide agency/professional's name & telephone #:

Name: _____ Ph: _____

May I contact the agency/person to thank them for referring you? Yes No Please initial: _____

CONCERNS

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems): _____

What are your hopes regarding your child's therapy? _____

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems? _____

Who is your child's primary care physician? _____

When was your child's last complete physical exam (mo/year)? _____

Has your child ever been treated for any of the following? If so, please circle and describe: Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions: _____

Who is your child's psychiatrist (if applicable)? _____

Has your child previously seen a therapist or psychiatrist? If so, what year? _____ Who did he/she see and for what reason? _____

About how many meetings did your child have? Was the experience helpful or not? How so? _____

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason: _____

Please list your child's current prescription medications with dosage (psychiatric and general health): _____

Please list any previous psychiatric medications (with dosage and dates): _____

Do you suspect or know if your child drinks alcohol or uses recreational drugs? _____
If so, what kind & how often? _____

Do you or anyone close to your child consider his/her use to be a problem? Yes No
If so, who? _____ Why? _____

How many times a week does your child exercise? _____ What type & how many minutes? _____

YOUR CHILD'S FAMILY

	BIOLOGICAL MOTHER	BIOLOGICAL FATHER
Current age (if deceased date, age & cause of death)		
Country of Origin (Race)		
Occupation		
Religious/Spiritual Affiliation (Cultural Issues if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together Never Coupled

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other _____

Who has current legal guardianship of child? (Please provide legal papers if they exist) _____

Please describe the current visitation schedule (if any) and type of communication with child's other parent(s): _____

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First Name	Biological, Adopted or Step	Current Age	School grade?	Male/Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	_____
Obsessive Compulsive Behavior	Yes No	_____
Depression	Yes No	_____
Suicide Attempts	Yes No	_____
Bipolar/Manic Depressive	Yes No	_____
Alcoholism	Yes No	_____
Substance Abuse	Yes No	_____
Domestic Violence	Yes No	_____
Eating Disorders	Yes No	_____
Obesity	Yes No	_____
Schizophrenia	Yes No	_____
Counseling or Psychotherapy	Yes No	_____
Psychiatric Hospitalizations	Yes No	_____

YOUR CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth

Age of mother at birth: _____ Length of pregnancy? _____ Weeks
 Were there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe: _____

Were there any complications during delivery? If so, please describe: _____
 Length of stay in the hospital? Mother: _____ (days) Child: _____ (days) Birth weight: _____
 Medications used during pregnancy? Please list: _____
 Smoking? Yes No How much? _____
 Alcohol intake? Yes No How much? _____ Drug intake? Yes No How much? _____

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each):
 Turn over _____ Crawl _____ Stand Alone _____ Walk Alone _____ Talk _____
 First Words _____ First Phrases _____
 Currently toilet trained? Yes No If yes, days? _____ Nights? _____
 Has your child wet or soiled himself after being trained? Yes No If yes, until what age? _____
 Enjoyed cuddling? Yes No Fussy, Irritable? Yes No More active than other babies? Yes No
 If your child has siblings, was development different in any way? Explain: _____

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

School Name: _____ Public Private

Street Address: _____

School District/County? _____ Phone: (____) _____

What preschool experience did your child have? _____

Where any problems detected in your child's kindergarten screening? Yes No If so, please explain: _____

Is your child in a regular classroom? Yes No Does your child have an IEP? Yes No

Has your child ever received tutoring? Yes No If so, please explain: _____

What are your child's typical grades? _____

What are your child's strongest and weakest points academically? _____

Are you satisfied with your child's educational program? Yes No Please explain: _____

Home/Family Life

What are 5 things that you enjoy most about your child? _____

What are some activities you engage in as a family? _____

Does your child participate in any religious or faith based group? _____

Does your child listen and obey instructions 75% of the time? Yes No _____

What are your discipline techniques? _____

What are **your** strengths personally and as a parent? _____

What are some of **your** areas of needed growth? _____

What are your **child's** strengths (things he/she is good at)? _____

What are your **child's** areas of needed growth? _____

Social and Community Engagement

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activities is he/she involved? _____

How does your child get along with other children? _____

Who are some of your child's closest friends? (first names) _____

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child changed school, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No
If yes, please describe: _____

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: _____

Your Child's Symptoms or Problems

How much are each of the following areas currently a problem for your child? (Please circle)

	Not at all	A little	Somewhat	Considerably	Terribly
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/Religious	1	2	3	4	5
Legal Problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (Physical, Emotional, Sexual)	1	2	3	4	5

Please add any other information that would help us help your child:
