Child Intake Form

Child's Name:_____
Date of Birth:_____ Gender: M F Other:_____
Parent's Info:
Single ☐ Married ☐ Separated/Divorced ☐ Remarried ☐ Widowed ☐
Date married/divorced (if applicable):_____
Mother's Name: _____ Age: _____
Father's Name: _____ Age: _____
Guardian or Other Parent: _____

Contact Info:
Mother's Home Phone:_____ Cell Phone:*_____
Father's Home Phone:_____ Cell Phone:*_____
Guardian's Home Phone: _____ Cell Phone: _____
If child is in CFS custody please provide CFS branch, contact name, phone & email:
_____
_____

What time of day is best?_____
Can we leave a voice message at this contact number?* Yes ☐ No ☐
Email:*_____
May we email you?* Yes ☐ No ☐
Address:_____
City:_____Postal Code:_____

In Case of Emergency:
Emergency contact:_____ Relationship:_____
Phone: (home)_____(cell)_____ (work)_____

Payment Method: Etransfer ☐ Cheque ☐ Visa/MasterCard ☐ Cash ☐

School Info:
Is child currently in public school? Y N If yes, which school: _____
What grade is child currently in? _____ Is child performing at the required level: _____

Medical Info:

Primary Care Physician:_____Contact info:_____

Medical conditions: _____

Previous medical conditions/surgeries: _____

Please list any current medications including natural supplements & vitamins:_____

_____

_____

Services Required:

Individual Child Therapy ☐ Family Therapy ☐ Other Group ☐

What issues brought the child to counselling:_____

_____

_____

_____

_____

_____

I often work with a therapy dog (hypoallergenic & non-shedding), is there any reason the child can not be around a therapy animal? Yes ☐ No ☐ If yes, please explain: _____

Have they previously received any type of mental health services? Yes ☐ No ☐

If yes, where: _____ when: _____

How long did they attend: _____ Did it help? _____

When could the child be available for appointments? Please check all that are possible.

	Morning	Afternoon	Evening
Monday	☐	☐	☐
Tuesday	☐	☐	☐
Wednesday	☐	☐	☐
Thursday	☐	☐	☐
Friday	☐	☐	☐
Saturday	☐	☐	☐

Conditions:

Treatment:
Counselling is a collaborative relationship that empowers diverse individuals, families, and groups to find appropriate solutions to issues and to accomplish mental health, wellness, education, relationship, and career goals. It is not advise giving or a quick fix. It requires time and a commitment to go through the process together. The counselling relationship is not judgmental, but accepting and supporting for the client as they make decisions and changes to their lives in order to help reach their goals.

Treatment Termination:
The counselling relationship will be terminated upon any of the following: 1) the client reaches their goals and no longer needs therapy, 2) the client-counsellor relationship is not conducive for the client's well-being, 3) there are issues of aggression or threats made against the therapist, 4) the client is referred to another therapist.

Referrals:
If a client requires more care than I am qualified to give, they will be referred to a professional who is capable of providing that level of treatment.

Fees & Cancelation Policy:
Fees for each session are to be paid prior to the beginning of the session. Notice of at least 24 hours is requested for cancellation unless for medical reasons.

Confidentiality:
As Professional Therapist, I adhere to a strict standard of confidentiality and code of ethics. All of the information shared will not be disclosed to anyone without permission from the client. Exceptions for disclosure: (1) When legal requirements demand material to be revealed for Federal or Provincial Court, (2) criminal code violations where physical and/or sexual abuse of children are involved, (3) whereby disclosure is required to prevent clear and imminent danger to the client or others. Most sessions are recorded by audio only and kept on a secure server, available only to myself and unless requested by court they are never released.

Minors:
When working with minors, confidentiality to the parent/guardian will only be broken with permission from the minor, or in cases of abuse, self-harm, suicidal plans, or violent threats. However, I will give progress updates as needed, share the general direction of therapy, and encourage the client to have open communication with the parent/guardian. When assessing a minor at the request of the court, CFS, or school, I will only provide all of the relevant information needed to make an assessment and recommendation, while also protecting the minor's privacy to the best of my ability. This will be explained to the minor so that they understand what is required to be shared and what may remain confidential.

I understand and agree to the content stated above:

Signed (minor):_____ Date_____

Signed (parent/guardian):_____ Date_____
(If under 18, parent/guardian signature)

PSYCHOLOGICAL ASSESSMENT:

Family

Who is the primary care giver? _____

Sibling Name	Gender	Age	General Characteristics	Relationship (close/conflicted)

Please describe the mother's personality and the child's relationship to her: _____
_____
_____

Please describe the father's personality and the child's relationship to him: _____
_____
_____

What traits do they have from the mother?_____
_____

What traits do they have from the father? _____
_____

What is the child's role in the family growing up? (Peacemaker, leader, problem-solver, etc…) _____
_____

How does the family deal with conflict? _____
_____

What is it like for them growing up in the family? _____
_____
_____
_____

How does the child relate to their siblings? _____
_____
_____

Psychiatric & medical history:

How has the child been feeling? _____

How long have they been feeling this way? _____

Please list any non-pharmacological treatments they are currently in:_____
_____

Have they ever been treated for psychiatric problems? Yes ☐ No ☐ Hospitalized? Yes ☐ No ☐
Have they ever been on any psychiatric medications? If so, please list. Yes ☐ No ☐ _____
_____
Has anyone in your family ever been hospitalized for mental health related issues, attempted or committed suicide? _____

Has the child ever experienced any of the following: If yes, how much does it interfere with their life?

Suicidal Thought	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
History of suicide attempts	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Self Harm	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Homicidal/violent thoughts	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
History of violent behaviour	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Paranoid thoughts	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Hallucinations	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Memory & cognitive problems	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Depression	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Anxiety	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10

Any significant additional problems or stresses at this time? Yes ☐ No ☐ If yes explain: _____
_____

Traumas or significant losses:
Has the child experienced or are they currently experiencing events that are emotionally, mentally, or physically traumatic? Yes ☐ No ☐ If yes, please explain:_____
_____
_____
(Please consider any from this list or others not listed: Abduction, bullying, chronic illness, cultural issues, criminal events, deaths, divorce/separation, emotional trauma, financial issues, hate crime, identity theft, internet fraud, isolation, loss of culture, loss of independence, medical/physical issues, sexual abuse, stalking, torture/war, witness of trauma, work related/job loss)
Have there been any issues of child abuse? Yes ☐ No ☐ If yes, has it been reported? Yes ☐ No ☐
If so, who was it reported to? _____ Were criminal charges laid? Yes ☐ No ☐
Who was the perpetrator of the abuse? _____
Please list any significant life changes or stressful events that they have experienced recently: _____
_____
_____

Lifestyle Assessment:
Please rate the child's overall satisfaction with the following:

	☹1———😟2———😐3———🙂4———😁5
Sleeping	1——— 2———3———4———5
eating	1——— 2———3———4———5
Family life	1——— 2———3———4———5
School	1——— 2———3———4———5
Other relationships	1——— 2———3———4———5

Do they drink alcohol? Yes ☐ No ☐ If yes, how many per week? _____
Do they smoke cigarettes? Yes ☐ No ☐ Do they use cannabis? Yes ☐ No ☐
Do they use any other recreational drugs? Yes ☐ No ☐
Do they have any addiction issues? (gambling, internet, shopping, pornography, gaming, alcohol, drugs)
Yes ☐ No ☐ If yes please list _____
Does anyone in the family have a history of substance abuse, addiction, physical or sexual abuse?
Yes ☐ No ☐ If yes please explain _____
_____

Education & Work (if applicable):
Current level of Education: _____
Education goals: _____
Current employer if working: _____ date started: _____
Job description:_____
Career goals: _____
Volunteer work:_____

Legal history:
Any outstanding legal matters? Yes ☐ No ☐ (child custody, criminal case, etc)
Probation Yes ☐ No ☐
Detention (past/current) Yes ☐ No ☐
Past legal matters? Yes ☐ No ☐

Spiritual/religious beliefs: _____
Who is the child's support system? (friends, church, family, professionals, neighbours, co-workers, virtual friends, children, partner, pets, other)_____
_____

Why did you decide that now is the time for therapy? _____
_____
_____
What are the short term goals or therapy? _____
_____
What are the long term goals for therapy? _____
_____

Client Attributes & Personality:
What are the child's strengths? _____
What are the child's weaknesses? _____
What are the things in life they view as the most important? _____
_____
Hobbies/interests? _____
Has there been any change in your level of interest? Y N If yes, please explain _____
_____

What do they do for fun and relaxation? _____

Who do they spend most of your time with? _____

Cognitive Behaviour:

Is the child a perfectionist? Yes ☐ No ☐

Do they have set routines, which if interrupted is upsetting? Yes ☐ No ☐

If yes, please explain _____

Do they check and recheck things that they or others have already done? Yes ☐ No ☐

If yes, please explain _____

Do they have unwanted thoughts repeating in their mind? Yes ☐ No ☐

If yes, please explain _____

How well has their memory been lately? Good ☐ Poor ☐

How well has their concentration been lately? Good ☐ Poor ☐

How well do they make day-to-day decisions? Easily ☐ With Difficulty ☐

Do they ever see or hear things that others don't? Yes ☐ No ☐ I don't know ☐

Do they think people are always talking about them negatively? Yes ☐ No ☐

Do they think people are out to get them? Yes ☐ No ☐

How well do they feel you relate to others? 0—1—2—3—4—5—6—7—8—9—10

Is there anything we missed or you think I should know or would find helpful? _____

_____

_____