CHILDREN'S MENTAL HEALTH SERVICES/REACH, INC.
35382 HWY 2 – GRAND RAPIDS, MN 55744

CHILD INTAKE FORM
(Please complete in Ink)

CHILD

1. Child's Name_____Sex_____Age_____DOB_____

2. Natural Child Yes / No If adopted, at what age_____ Foster since _____

3. Parent's Names (include step-parents, foster parents, inc.)

   _____

   _____

4. Comments about custody and visitation (if applicable):

   _____

   _____

5. Primary reason you are concerned about your child?

   _____

   _____

   _____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

a.
- _____ Sleep problems
- _____ Lack of interest in activities
- _____ Unassertive
- _____ Fatigue/low energy
- _____ Concentration problems
- _____ Appetite/weight changes
- _____ Withdrawal

- _____ Morbid thoughts
- _____ Suicidal thoughts or threats
- _____ Suicidal plans / attempts
- _____ Mood swings
- _____ Depression
- _____ Changed level of activity
- _____ Cries easily

b.
- _____ Forgetful/memory problems
- _____ Short attention span
- _____ Aggressive behavior
- _____ Can't sit still
- _____ Not interested in peers
- _____ Picked on / bullied by peers

- _____ Talks excessively / interrupts
- _____ Easily distracted
- _____ Irritable
- _____ Impulsive
- _____ Difficulty following rules
- _____ Problem completing schoolwork

c.
_____ Excessive worry / fearfulness
_____ Anxiety or panic attacks
_____ Social fears, shyness
_____ Separation problems
_____ Bedwetting / soiling
_____ Headaches, stomachaches
_____ Odd beliefs / fantasizing
_____
_____ Nightmares
_____ Frequent tantrums
_____ Resistive to change
_____ School refusal
_____ Perfectionism
_____ Odd hand / motor movements
_____ Hallucinations
_____

d.
_____ Lying
_____ Trouble with the law
_____ Running away
_____ Truancy, skipping school
_____ Hurting others sexually
_____ Alcohol / drug use
_____ Argumentative / defiant
_____ Swears
_____ Blames others for mistakes
_____ Stealing
_____ Being destructive
_____ Fire setting
_____ Hurting others / fighting
_____ Acts as if has no fear
_____ Short tempered
_____ Easily annoyed / annoys others
_____ Discipline problem
_____ Angry and resentful

Brothers and Sisters

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

SCHOOL HISTORY

1. Present School: _____Grade: ____ Teacher:_____
2. Has child ever repeated any grade? _____
3. Is child in special education services? No ____ Yes, what kind? _____
4. Please describe academic or other problems your child has had in school

_____

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. **Pregnancy**

Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____

Delivery: Normal _____ Breech _____ Cesarean _____ Transectional _____
Full-term _____ Premature _____ if premature, number of weeks _____

Birth Weight: _____

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)

_____

2. **Developmental History**

- State approximate age when child did the following:

  Walked alone _____ Said first word _____ Used 2-word phrases _____

- Understood and followed simple directions _____
- Reasonably well toilet trained _____
- Did child cry excessively? _____ Rarely cried _____

3. **Health History of Child**

In the first two years, did your child experience: ___Separation from mother, ___Out of home care, ___Disruption in bonding, ___Depression of mother, ___Abuse, ___Neglect, ___Chronic pain, ___Chronic Illness, ___Parental Stress

- Child's Doctor: _____
- Date of last physical exam: _____
- Vision problems? Yes _____ No_____ Hearing problems? Yes _____ No _____
- Dental problems? Yes ____ No ____
- Any head injuries or loss of consciousness? Yes _____ No _____
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No _____ Yes – describe and give dates _____

- Is your child currently taking any medications? No ____ Yes ____ name medications

_____

- List any medicines previously used for emotional problems: were they helpful? ____

  _____

- Allergies to drugs or medicines? No ____ Yes ____ (list) _____
- Allergies to any foods? No ____ Yes ____(list) _____
- Are there any foods that you limit or do not give this child? No ____ Yes ____

  (list) _____.
- Allergies to environmental conditions? No ____ Yes ____(list) _____
- Does anyone in the household smoke? No ____ Yes ____
- About how many hours does this child watch TV, videos, etc per day _____
- Are you afraid someone you know may injure/harm this child? No ____ Yes ____

  National Domestic Violence Hotline 1-800-799-7233
- Does this child have a Health Care Directive? No ____ Yes ____

  If yes, please list where (clinic) it is on file _____
- Any previous psychological or psychiatric treatment? No _____ Yes _____

  Whom/where _____when_____
- Any previous testing (school/psychological)? No _____ Yes _____

  Whom/where _____when_____
- Do you think your child's use of chemicals is a problem? No _____ Yes _____

  Type: Alcohol _____ Marijuana _____ Other drugs _____

  Comments: _____

Family History:

Chemical use (now & past): No _____ Yes _____ Which parent _____

Type: Alcohol _____ Marijuana _____ Other drugs_____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

_____

_____

Has child witnessed domestic violence? __Y, __N, Specify: _____

_____

How is your child disciplined? Please list each method and frequency of use: _____

_____

_____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? __Y, __N, __Suspected. Specify: _____

_____

2. Has your child been physically abused? __Y, __N, __Suspected. Specify: _____

_____

3. Has your child been sexually abused? __Y, __N, __Suspected. Specify: _____

_____

4. Other stressors or traumas? _____

_____

What are your child's strengths?

Any additional comments or information that would be helpful to us?

Signature of person completing form / relationship to client:

_____ Date: _____
Name Relationship

See IFCSP for annual review of medical status