CHILD CLIENT INTAKE FORM

AXIOS BEHAVIORAL HEALTH

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy.

Patient Name:_____
(Last) (Given) (Preferred) (Middle Initial)

Birth date: _____/_____/_____ Age:_____ Gender: Male Female Transgender

Person filling out form: _____ Relationship to child: _____

Mother's name:_____ Date of Birth: _____

Father's name:_____ Date of Birth: _____

Parent marital status: Never married Partnered Married Separated Divorced

If separated or divorced, please provide date: _____

If parents are unmarried, separated or divorced, who has legal and physical custody of the child: _____

_____

Current address: _____
(city) (state) (zip)

Home phone:_____ May we leave a message? Yes No

Child's cell phone: _____ May we leave a message? Yes No

Parent phone: _____ May we leave a message? Yes No

Email:_____ May we email you?* Yes No

*NOTE: Emails may not be confidential

Who may we contact in case of an emergency: _____ Telephone number_____

Referred by: Insurance company Internet search Word of mouth Advertisement Other:_____

Primary insurance co & identification number: _____

Insurance subscriber name and date of birth: _____

Secondary insurance identification number: _____

Insurance subscriber name and date of birth:_____

Who suggested that you seek assessment and/or counseling for your child?
School teacher School counselor Myself as a caregiver Other: _____

Describe the overall problem that led you to seek help for your child:
_____
_____
_____

Describe your child's school experience: _____
_____
_____

Describe your child's interactions with parents: _____
_____
_____

Describe your child's interactions with siblings: _____
_____
_____

Describe your child's interactions with peers: _____
_____
_____

Describe your child's ability to complete tasks and follow directions: _____
_____
_____

My child appears to have high levels of stress: Yes No

If yes, please explain: _____

Describe your child's sleep patterns: _____
_____

Describe your child's eating patterns: _____
_____

Describe your child's physical activity level: _____
_____

Has your child experienced a significant trauma: Yes No

If yes, please explain: _____

Quick Check

Check the characteristics below that describe your child.

Depressed/Sad	Happy	Friendly	Angry
Agreeable	Argumentative	Suicidal	Aggressive
Anxious/Worried	Lacking Social Skills	Hyperactive	Lacking Energy

I have reason to suspect my child has been abused (emotionally, sexually and/or physically): Yes No
Please explain: _____

Medical History

Birth: Duration of labor: _____
Type of delivery: _____
Difficulties: _____
Birth weight: _____

Infancy: Age of weaning: _____
Feeding problems? _____
Approximate age of walking: _____
Approximate age of talking: _____

Any behavior such as head banging, rocking, etc. during infancy/ toddlerhood? Yes No
If yes, please explain: _____

Does your child have difficulty separating from his/her parents? Yes No
If yes, please explain: _____

Has your child had any severe, long-term illnesses or accidents? Yes No
If yes, please explain: _____

Does your child currently have any medical problems? Yes No
If yes, please explain: _____

Is your child on any medication? Yes No
If yes, please list: _____

Does your child have any allergies? Yes No
If yes, please explain: _____

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate family member affected.

Autism Spectrum	Yes	No	_____
Attention Deficit	Yes	No	_____
Depression	Yes	No	_____
Anxiety Disorder	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

Other Information

Is your child currently receiving any other mental health services? Yes No
If yes, reason for change:_____

_____

Has your child been prescribed psychiatric medication in the past? Yes No
If yes, please list:_____

_____

Has your child been psychiatrically hospitalized in the past? Yes No
If yes, please list dates and locations:_____

_____

Please list your child's strengths: _____

_____

_____

What are your goals for therapy/what would you like to accomplish?

_____

_____

_____

By signing below, I am acknowledging that I have chosen to receive mental health services for my child in the form of evaluation and psychotherapy from Axios Behavioral Health LLC. My decision is voluntary and I understand that I may terminate these services at any time. I also understand that during the course of treatment me and/ or my child may need to discuss material of an upsetting nature in order to resolve my problems. Further, I understand it cannot be guaranteed that me or my child will feel better after completion of treatment.

_____ _____

Signature of parent Date