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MAKING THE CONNECTION

CHILD PATIENT INTAKE FORM

(Please Print Clearly)

FAMILY INFORMATION

(List all family and household members)

Name	Relationship	Age	Occupation/Grade	Residing with You
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

PARENT'S MARITAL/RELATIONSHIP HISTORY

(List all marital or partner relationships including present)

Name of Spouse/Partner	Date Married	Terminated by	Date
		Divorce Death Separation	
		Divorce Death Separation	
		Divorce Death Separation	
		Divorce Death Separation	
		Divorce Death Separation	

Family History	Age of Living	Age of Death	Date of Death	Cause of Death
Father				
Mother				
Sister 1				
Sister 2				
Sister 3				
Sister 4				
Brother 1				
Brother 2				
Brother 3				
Brother 4				

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How does the child get along with:

Mother:_____ Father:_____

Sister(s):_____ Brother(s):_____

Who is the child closest with in the family?_____ **Who disciplines the child?**_____ **How?**

Usually for what reason?_____

Do the parents differ on discipline? Yes No If yes, please explain:

The child spends most of his/her time with: Alone with younger children with children same age with adults

What are the child's major interests or hobbies?

Do you feel your child is having difficulties at home? Yes No If yes, please explain:

When and how did this problem begin?

Are there any past or present family problems that may have contributed to the child's difficultites? Yes No
If yes, please explain:

LAURYN SALASSI GILLIAM, PhD, LMFT

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PREGNANCY, BIRTH AND DEVELOPMENT HISTORY

Were there complications during pregnancy? Yes No If yes, please explain:

Pregnancy:_____Months **Birth Weight:** _____Pounds_____Ounces

Please describe mother's and child's health during and after birth:_____

Age First: Sat up_____Walked_____Toilet Trained_____Spoke 1st words_____Spoke Sentences_____

If adopted, does child know? Yes No

MEDICAL DATA

Childhood Illness (check all that apply):

High Fevers	Seizures	Measles	Meningiti	Ear Infections	Accidents
Mumps	Mono	Frequent Colds	Head Injuries	Chicken Pox	Other

Hospitalization (Please list age during hospitalization and reason):

Has your child ever had problems in the following areas? if yes, explain:

Hearing: Does child wear a hearing aid? Yes No _____

Vision: Does child wear glasses? Yes No _____

Speech_____

Does child have allergies? Yes No If yes, please list:

Is child presently taking any medications? Yes No If yes, please list:

Child's physician:_____**Date of last exam:**_____

Check any of the following which present a problem for you or child and explain below:

Eating	Sleeping	Nail biting	Toilet accidents	Over active	Nightmares
Thumb sucking	Dressing, bathing	Temper tantrums	Daydreaming	Unusual fears	Bed wetting

Getting along with Friends Family Others:_____

Explain:_____

Has child ever had any of the following exams?

Psychological Yes No If yes, list date_____ **Neurological** Yes No If yes, list date_____

Psychiatric Yes No If yes, list date_____ **Counseling** Yes No If yes, list date_____

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EDUCATION HISTORY

List schools attended by child (include nursery and kindergarten if applicable):

1._____ 3._____

2._____ 4._____

Age started kindergarten:_____ **Has child repeated any grade?** Yes No If yes, please list:

_____

What are child's feelings toward school?_____

What are your feelings about your child's current educational program?_____

Do you feel your child is having difficulties in school? Yes No If yes, please explain:

_____

When and how did this problem begin?_____

Are there any past or present family problems that may have contributed to the child's difficulties?

Yes No If yes, please explain:

Please list any additional information you feel may be helpful in understanding your child:

PRINTED NAME	PARENT/LEGAL GUARDIAN SIGNATURE	DATE
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