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370 Queens Ave, Suite 100

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Phone: (519) 936-0108

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The information requested below is very important to understanding your child/adolescent client life experiences and critical to identifying treatment goals and interventions. Please answer each item as thoroughly as possible or enter N/A if not applicable to your client. Please type your responses into the grey boxes.

# CHILDREN’S AID SOCIETY CHILD OR

# YOUTH INTAKE FORM

CHILD’S FULL NAME       DATE OF BIRTH

BIRTHPLACE       DATE FORM COMPLETED:

M F
[ ]  [ ]

CHILD’S RACE/ETHNICITY

## CURRENT SOCIAL WORKER’S CONTACT INFORMATION:

NAME       PHONE #     -     -

EMAIL       FAX #     -     -

MAILING ADDRESS

Address Line 1
Address Line 2
City, Province, Postal Code

CHILD’S SCHOOL       GRADE

SCHOOL PHONE #     -     -      TEACHER’S NAME

DESCRIBE ANY ACADEMIC OR SOCIAL DIFFICULTIES AT SCHOOL

(include school report if available)

## CURRENT PLACEMENT INFORMATION

CURRENT FOSTER/GROUP HOME PARENTS

HOME PHONE     -     -      CELL PHONE     -     -      EMAIL

MAILING ADDRESS

Address Line 1
Address Line 2
City, Province, Postal Code

WHEN WAS CHILD PLACED WITH CURRENT GUARDIANS

EXPECTED DURATION OF CURRENT PLACEMENT

NUMBER AND DURATION OF PAST PLACEMENTS (Include nature of past placements and age)

LIST ALL MEMBERS OF THIS CHILD’S FOSTER OR GROUP FAMILY MEMBERS

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | AGE | RELATIONSHIP | GRADE / OCCUPATION |
|       |    |       |       |
|       |    |       |       |
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|       |    |       |       |

## BIRTH PARENT CONTACT INFORMATION

MOTHER’S NAME      DATE OF BIRTH (AGE)

HOME PHONE     -     -      CELL PHONE     -     -      EMAIL

MAILING ADDRESS

Address Line 1
Address Line 2
City, Province, Postal Code

FATHER’S NAME       DATE OF BIRTH (AGE)

HOME PHONE     -     -      CELL PHONE     -     -      EMAIL

MAILING ADDRESS

Address Line 1
Address Line 2
City, Province, Postal Code

## BIRTH PARENT BACKGROUND INFORMATION

(Briefly describe any psychiatric illnesses, trauma, domestic violence hx, criminal history, strengths/vulnerabilities)

MOTHER’S HISTORY

FATHER’S HISTORY

LIST ALL MEMBERS OF THIS CHILD’S BIRTH FAMILY MEMBERS

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | AGE | RELATIONSHIP | GRADE / OCCUPATION |
|       |    |       |       |
|       |    |       |       |
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## CHILD WELFARE HISTORY

REASON FOR HISTORICAL OR CURRENT CAS INTERVENTION

CURRENT WARDSHIP STATUS

DESCRIBE CURRENT ACCESS ARRANGEMENTS

HOW DOES THE CHILD UNDERSTAND THEIR BEING IN CAS CARE

DESCRIBE ANY EXPERIENCES OF RELATED CHILD TRAUMA (child maltreatment, abuse, neglect, exposure to domestic violence, apprehension)

## CHILD’S PRESENTING CONCERNS

(Describe in detail any psychological, emotional, relationship or behavioral concerns + note when the problems began)

CHILD’S CURRENT PRESENTING DIFFICULTIES

DESCRIBE ANY SELF HARMING OR SUICIDAL BEHAVIOR (list date of most recent incident)

DESCRIBE ANY OF THE CHILD’S FEARS OR WORRIES

DESCRIBE ANY ADDITIONAL TRAUMAS THE CHILD EXPERIENCED

(Accidents, medical trauma, fires, etc)

DESCRIBE ANY OF THE CHILD’S SIGNIFICANT LOSSES (Family members, pets, friendships, schools)

## CHILD’S STRENGTHS AND AREAS OF RESILIENCY

CHILD’S INTERESTS (i.e. sports, computers, games, music, art, drama, hobbies)

CHILD’S UNIQUE STRENGTHS + PERSONAL QUALITIES

(intuition, creativity, intelligence, humor, supports, etc)

DESCRIBE THE CHILD’S PAST AND CURRENT SOCIAL SUPPORTS

(Friends, teachers, coaches, pets, extended family members, past counselors, etc)

IDENTIFY GOALS YOU WOULD LIKE THE CHILD TO ACHIEVE THROUGH THERAPY?

## MEDICAL INFORMATION

NAME OF PRIMARY CARE PHYSICIAN

PHONE#     -     -      FAX # (If available)     -     -

LIST ANY PRESCRIBED OR NATURALPATHIC MEDICATIONS THE CHILD IS NOW TAKING

LIST ANY MAJOR HISTORICAL OR CURRENT HEALTH PROBLEMS

DEVELOPMENTAL OR MENTAL HEALTH DIAGNOSIS

(List any diagnosis of psychiatric and/or developmental disabilities + how impacts child’s functioning)

LIST ANY KNOWN ALLERGIES

## ADDITIONAL INFORMATION

LIST ANY OTHER AGENCIES INVOLVED WITH CHILD OR THEIR FAMILY

DESCRIBE ANY ADDITIONAL INFORMATION RELEVANT TO THE CHILD’S THERAPY

LIST ANY CONCERNS OR QUESTIONS REGARDING THERAPY

Thank you for your time spent in completing this detailed intake form.