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The information requested below is very important to understanding your child/adolescent’s 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 child. Please type your responses into the grey boxes.

# CHILD OR YOUTH INTAKE FORM

CHILD’S FULL NAME     DATE OF BIRTH

M F

[ ]  [ ]

CHILD’S RACE/ETHNICITY

BIRTHPLACE       DATE FORM COMPLETED:

CHILD’S SCHOOL       GRADE

SCHOOL PHONE #     -     -      TEACHER’S NAME

DESCRIBE ANY ACADEMIC OR SOCIAL DIFFICULTIES AT SCHOOL

## 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

LIST ALL MEMBERS OF THIS CHILD’S BIRTH OR BLENDED FAMILY MEMBERS

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | AGE | RELATIONSHIP | GRADE/OCCUPATION |
|       |    |       |       |
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FOR BLENDED FAMILIES

(Blended families are defined as families where the child’s birth parents no longer live with one another and have formed a separate family unit, with or without a new partner or additional children)

CHILD CUSTODY AND ACCESS INFORMATION

PROVIDE DETAILS OF THE CURRENT CUSTODY ARRANGEMENT

(Is there a separation agreement, interim, or full custody order in place, how does the order define parental custody, i.e. sole custody with other parent access/sole custody with access; joint custody)

HOW YOUR CHILD’S OTHER PARENT FEEL ABOUT YOUR CHILD ATTENDING THERAPY:

(When the child is having regular access to the other parent, their written consent for treatment is required prior to treatment beginning)

HOW CAN HE/SHE BE CONTACTED TO PROVIDE CONSENT FOR TREATMENT?

DESCRIBE ANY CONCERNS ABOUT HE/SHE PARTICIPATING IN THE CHILD’S TREATMENT:

## BIRTH PARENT BACKGROUND INFORMATION

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

MOTHER’S HISTORY

FATHER’S HISTORY

## HISTORY OF CHILD TRAUMA

(Describe in detail any experiences of child maltreatment, abuse or neglect; exposure to domestic violence; or any other traumas such as accidents, fires, medical trauma, CAS apprehension; significant losses)

## CHILD’S PRESENTING CONCERNS

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

CHILD’S CURRENT PRESENTING DIFFICULTIES

WHAT HAS HELPED WITH THE CHILD’S DIFFICULTIES THUS FAR?

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

DESCRIBE ANY OF THE CHILD’S FEARS OR WORRIES

DESCRIBE YOUR CHILD’S SOCIAL RELATIONSHIPS + SKILLS

## 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, humour, supports, etc)

DESCRIBE YOUR CHILD’S PAST AND CURRENT SOCIAL SUPPORTS (Friends, teachers, coaches, pets, extended family members, past counselors, etc)

IDENTIFY GOALS YOU WOULD LIKE YOUR 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

LIST ANY KNOWN ALLERGIES

DEVELOPMENTAL OR MENTAL HEALTH DIAGNOSIS
(List any diagnosis of psychiatric and/or developmental disabilities + how impacts child’s functioning)

## ADDITIONAL INFORMATION

LIST ANY OTHER AGENCIES INVOLVED WITH YOUR CHILD OR FAMILY

DESCRIBE ANY ADDITIONAL INFORMATION RELEVANT TO YOUR CHILD’S THERAPY

LIST ANY CONCERNS OR QUESTIONS REGARDING YOUR CHILD’S THERAPY

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