Prana Counseling Services, LLC

Child Intake Form

Thank you for taking the time to complete this form completely and thoroughly. This form has been designed to provide necessary information to Prana Counseling Services, LLC before our initial visit in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information that you think may be helpful to me in understanding you and/or family. All information provided by you is strictly confidential and will not be released to anyone without your written consent.

GENERAL INFORMATION

Today's Date:_____Person Completing Form: _____

Child's Name:_____ Child's Nickname:_____

How did you hear about Prana Counseling Services? Circle one:
Family member Friend Internet Other Therapist Other Clinic
Doctor Other: _____

Home Address:_____

City_____State_____Zip_____

Your Date of Birth (of your child):_____ Age:_____

Sex (how does your
child identify?): _____ Race: _____

Religion:_____ Email: _____

School Attending:_____Contact at School (name and number):_____

Parent/Guardian:
Main Number: _____ Okay to leave a message? Y or N

Work Number:_____ Okay to leave a message? Y or N

Cell Number: _____ Okay to leave a message? Y or N

Email: _____

Occupation: _____ Place of Employment:_____

_____ Relationship Status: _____

Parent/Guardian:

Main Number: _____ Okay to leave a message? Y or N

Work Number:_____ Okay to leave a message? Y or N

Cell Number: _____ Okay to leave a message? Y or N

Email: _____

Occupation: _____ Place of Employment:_____

_____ Relationship Status: _____

Whom does child live with? _____

FAMILY SYSTEM INFORMATION:

Please provide me information regarding the child's primary family system. If there are multiple families within the child's world (i.e, divorced and remarried with stepsiblings) please use the back of this sheet of paper to tell me briefly about each family dynamic.

NAME	AGE	DOB	RELATIONSHIP	HOW DO THEY GET ALONG IN FAMILY?	ADDITIONAL INFORMATION

CURRENT SYMPTOMS

Please describe why you are seeking therapy services for your child at the present time.

_____

_____

Current/Past Stressors

Please Circle any of the stressors your child has experienced over the past 12 months. You will be asked to elaborate on the circled stressors below.

Divorce	Substance Abuse	Death of a Parent
Blended Family	Friend Dynamics	Sexual Abuse
Physical Abuse	Neglect	Domestic Violence
Physical Health	Birth of a Sibling	Sexual Identity
Parental Job Loss	Parental Relationship	Body Insecurities
Social Pressure	Sadness	Step Parents
Eating Disorders	Social Media	Grades
Sleeping Disturbances	Mental Health of a Family member	School
Social Anxiety	Change in Living Condition	Cutting

Other:_____

Please tell me more about any circled stressors above:_____

_____

_____

_____

How long has your child been experiencing these problems? _____

Marital Status Of Parents (circle one): Married Remarried Divorced Separated Widowed Single Cohabitants

If married, how long have you been married or remarried? _____

If divorced, how long have you been divorced?_____

If divorced, who has physical custody?_____ Is it full or joint? _____

Who has legal custody? _____ Is it full or joint? _____

PLEASE PROVIDE A COPY OF THE CUSTODY AGREEMENT

MENTAL HEALTH HISTORY

Please circle all that apply to your child:

Addictive Behaviors	Agitation	Aggressive Behavior	Anger and Rage
Anorexia	Anxiety	Attachment Problems	Body tension
Bulimia	Chronic Fatigue	Compulsive behavior	Conflict with peers
Constipation	Depression	Despair	Difficulty Sleeping
Dissociative Episodes	Early Trauma	Emotional Expression	Emotionally Reactive
Emotionally Overwhelmed	Fear and Anger	Emotionally Vacant	Headaches/Migraines
Hyper-vigilance	Impulsivity	Irritability	Irritable Bowel
Lacking Boundaries	Mental Calming	Mood Swings	Motivation
Nightmares	Night Terrors	Obsessive Negative Thoughts	Obsessive Worry
Panic Attacks	Paranoia	Perfectionism	Phobias
Physical Tension	Poor Concentration	Seizures	Self-Esteem
Self-Injurious Behavior	Oppositional/Defiant	Sexual Identity Questions	Short-Term Memory Loss
Sleep Walking	Stomachaches	Suicidal Thoughts	Trauma
Verbal Expression	Tantrums	Withdrawn	Working Memory

Sensory Problems	Vocal/Motor Tics	Soiling	Isolation

Other:_____

Which of the above behaviors are the most concerning to you and your child? Why? _____

_____

_____

_____

_____

MEDICAL HISTORY

Primary Care Provider:_____

Medications your child is currently taking?:_____

_____

Have you (or your family member) previously attended therapy? Y or N
If Yes, for what reason? _____

How was your child's experience (circle one)? Helpful Somewhat Helpful Not Helpful

Has your child ever experienced any of the following? Please circle one and describe.

Chronic illness:_____

Surgeries: _____

Hospitalizations:_____

High Fevers:_____

Head Injuries:_____

Seizures: _____

Eating Problems:_____

Sleeping Problems:_____

Enuresis:_____

Problems During Birth: _____

Other: _____

Is your child adopted? Y or N

If Yes, how old was child when adopted? _____

Are you aware of the biological parents mental/medical health or the conditions, which the child was exposed to before adoption? If so, Please explain:

_____

_____

_____

_____

If this is your biological child, was the pregnancy planned? Y or N

Was the child born on time? Premature? Overdue? _____

Did the mother experience any stress during delivery? _____

_____

Did the mother experience depression after delivery? _____

_____

Is there any other information that would be important for me to know about and you or your child?_____

_____

_____

_____

_____

Signature of Client (or Guardian if child is under the age of 15):

_____ Date:_____

Signature of Therapist:

_____ Date: _____

Alison Biggs MA, LPCC, NCC