THE CENTER
for Creative Arts and Play Therapy

Child Intake Form

Client Information

Name:

Date of Birth:

Today's Date:

Phone #:

Email:

Is it ok to leave messages at this phone number? ☐ Yes ☐ No May we contact you via email? ☐ Yes ☐ No

Emergency Contact Name:

Phone #:

SEX ASSIGNED AT BIRTH: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

Gender: ☐ Prefer not to disclose

Sexual Orientation: ☐ Prefer not to disclose

Race: ☐ Prefer not to disclose

Education

District:

Grade:

School:

Teacher:

Academic strengths and challenges?

Friendships (Number, quality, etc.):

Are there any behavior/social concerns?

Family Information

Parent: Age:

Lives with child? ☐ Yes ☐ No Occupation:

Parent: Age:

Lives with child? ☐ Yes ☐ No Occupation:

PARENTS' MARITAL STATUS: ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ _____

Are there any custody orders in place related to this child? ☐ Yes ☐ No

If yes, please explain:

Step-parent?: Age:

Lives with child? ☐ Yes ☐ No Occupation:

Step-parent?: Age:

Lives with child? ☐ Yes ☐ No Occupation:

Are there any siblings? ☐ Yes ☐ No If no, please skip to the next section.

Name: Age: Lives with child? ☐ Yes ☐ No

Name: Age: Lives with child? ☐ Yes ☐ No

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Name: Age: Lives with child? ☐ Yes ☐ No

Name: Age: Lives with child? ☐ Yes ☐ No

Additional household members:

Family History

Please describe your relationship with your child:

Please describe the relationship between you and your child's other parent:

Please list any additional family members who are significant, as well as any pets:

If there are any current family stressors, or past family trauma, please list here:

Parent psychiatric and/or trauma history (including diagnoses, traumatic events, etc.):

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

If yes please explain:

Stressors

What stressors has your child or family experienced or is currently experiencing? Please check all that apply:

- ☐ Alcohol/Drug Use
- ☐ Attempted Suicide
- ☐ Death/Loss
- ☐ Family Conflict
- ☐ Financial Crisis
- ☐ Frequent Moves
- ☐ Injuries/Disabilities
- ☐ Legal Difficulties
- ☐ Physical/Sexual Abuse
- ☐ Psychiatric Illness
- ☐ Serious illness
- ☐ Other _____

Support System

Do you have a support system? ☐ Yes ☐ No

Who can you turn to when you need help?

Any spiritual beliefs or cultural beliefs important to your family:

Is your home environment safe? ☐ Yes ☐ No

If no, please explain:

Are there firearms in the home? ☐ Yes ☐ No If yes, how are they stored?

Child/Developmental History

Was your child adopted? ☐ Yes ☐ No

If yes, at what age and from where? Please also describe the level of openness:

Were there any difficulties or emotional stressors during pregnancy? ☐ Yes ☐ No

Please list any complications at birth and/or infancy:

Approximate milestone ages:

Talking: Walking: Toilet Training:

Any bedwetting or toileting difficulties currently:

What symptoms are concerning about your child? Please check all that apply:

- ☐ Appetite Problems
- ☐ Concentration Problems
- ☐ Emotional Dysregulation
- ☐ Energy Levels
- ☐ Flashbacks
- ☐ Head/Bellyaches/Racing Heart
- ☐ Hopelessness
- ☐ Low Interest/Motivation
- ☐ Mood Swings
- ☐ Nightmares
- ☐ OCD Symptoms
- ☐ Panic Attacks
- ☐ Self-harm/Suicidal Thoughts
- ☐ Trouble Sleeping
- ☐ Other _____

How frequently do these difficulties occur?

What effect do these have on life? ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

How long have these difficulties persisted?

Does your child eat a healthy variety of foods? ☐ Yes ☐ No Hours of sleep per night? ☐ hours

List your child's strengths, hobbies and interests:

Mental Health History

Has your child experienced any of the following in the past 90 days or have a history of being diagnosed with any of the following at any time? Please check all that apply:

- ☐ ADHD
- ☐ Anger/Rage
- ☐ Anxiety/Social Anxiety
- ☐ Autism
- ☐ Defiance
- ☐ Depression/DMDD
- ☐ Eating Disorder/ARFID
- ☐ Other:
- ☐ Hospitalization
- ☐ Learning Disorder
- ☐ Mood Swings
- ☐ Obsessive/Intrusive Thoughts
- ☐ Panic/Phobia
- ☐ Paranoia/Delusions
- ☐ Poor Sleep Patterns
- ☐ PTSD
- ☐ Racing Thoughts
- ☐ School Attendance Issues
- ☐ Self Injury/Harm
- ☐ Thoughts of Harming Others
- ☐ Thoughts of Suicide
- ☐ Violence
- ☐ Weight Gain/Loss

Has your child ever been admitted to the hospital for mental health reasons? ☐ Yes ☐ No

If yes please explain:

Any work with a psychiatrist/therapist in the past? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Previous provider(s):

Dates seen:

CHILD & ADOLESCENT TRAUMA SCREEN-CAREGIVER (CATS-C)

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES or NO if it happened to the child, to the best of your knowledge.

1. Serious natural disaster, like a flood, tornado, hurricane, earthquake, or fire? ☐ Yes ☐ No
2. Serious accident or injury, like a car/bike crash, dog bite, or sports injury?..... ☐ Yes ☐ No
3. Robbed by threat, force, or weapon?..... ☐ Yes ☐ No
4. Slapped, punched, or beat up by someone in your family?..... ☐ Yes ☐ No
5. Slapped, punched, or beat up by someone not in the family?..... ☐ Yes ☐ No
6. Seeing someone in the family get slapped, punched, or beat up?..... ☐ Yes ☐ No
7. Seeing someone in the community get slapped, punched or beat up?..... ☐ Yes ☐ No
8. Someone older touching the child's private parts when they shouldn't?..... ☐ Yes ☐ No
9. Someone forcing or pressuring sex, when that person could not say no?..... ☐ Yes ☐ No
10. Someone close to the child dying suddenly or violently?..... ☐ Yes ☐ No
11. Being attacked, stabbed, shot at, or hurt badly?..... ☐ Yes ☐ No
12. Seeing someone attacked, stabbed, shot at, or hurt badly?..... ☐ Yes ☐ No
13. Stressful or scary medical procedure?..... ☐ Yes ☐ No
14. Being around war?..... ☐ Yes ☐ No
15. Other stressful or scary event?..... ☐ Yes ☐ No

Describe:

Sachser, C., Berliner, L., Holt, T., Jensen, T. K., Jungbluth, N., Risch, E., Rosner, R., & Goldbeck, L. (2017). Child and Adolescent Trauma Screen (CATS)

Medical History

Is your child currently taking any medications? ☐ Yes ☐ No

Name(s)/Dosage:

Does your child have any health conditions, injuries, or recent hospitalizations? ☐ Yes ☐ No

If yes, please list symptoms and treatments they are undergoing:

Any allergies? ☐ Yes ☐ No

If yes, please list:

Is there a history of head injury or seizure? ☐ Yes ☐ No

If yes, please explain:

Do your child experience physical pain that causes mental health issues? ☐ Yes ☐ No

Health care providers, including PCP and prescribers:

Miscellaneous

What kind of opportunities does your child have to be physically active?

What kind of opportunities does your child have to play outdoors?

How much time each day does your child use technology inside and outside of school?

Goal Information

Please answer the following questions to the best of your ability:

Why are you seeking treatment for your child at this time?

What would you like to change about yourself or your circumstances?

What are previous strategies that have been tried to help with these concerns?

What are goals that you have for treatment?

By signing below, I agree that I have completed this form to the best of my ability and knowledge. I agree to inform the therapist of any changes in the above information.

Printed Name Signature Date