Colorado State University
Center For Family and Couple Therapy
Child Intake Form

Case Number _____ Today's Date_____

Child's Name_____ Date of Birth_____

Child's Ethnicity _____

Parent(s) / Guardian(s) name(s)_____

Parent(s) / Guardian(s) phone number(s) _____

Current Household Composition (names, ages, and relationship of those living with the child)_____

_____

_____

Child's School/ Daycare _____

Grade _____ Teacher(s) _____ Phone Number(s) _____

CHILD'S HISTORY

Is your child adopted? yes no

Has your child ever been or is he/she currently in Foster Care? yes no

Has your child received any previous counseling or treatment? yes no

Does your child have any medical problems, injuries, or allergies? yes no

Were there any problems during pregnancy or birth? yes no

Has your child experienced abuse, neglect, significant separations, or other trauma? yes no

Does your child have difficulty at school or daycare? yes no

Does your child get along with peers? yes no

Does your child get along with adults? yes no

Does your child have unusual eating patterns? yes no

Does your child have unusual sleeping patterns? yes no

What are you most concerned about? _____

_____

What changes would you like to see as a result of therapy? _____

_____

What are your child's three greatest strengths? _____

_____

FAMILY HISTORY

Parent's marriages, separations, divorces _____

_____

Current custody status _____

Visitation arrangements _____

_____

What are your main approaches to discipline and which have been most successful? ____

_____

_____

As a parent, what would you most like to work on? _____

_____

As a parent, what are your greatest strengths? _____

_____

Child's Medical History

Primary Physician:

Name:_____ Address: _____ Phone Number:_____

When did your child last see a physician?

_____

Please list any mental health and/or medical problems within the last five years:

_____

_____

_____

Client Medication Log

	Name of Med	For what Diagnosis	Dosage	Frequency Taken	Approx. Date Started	Prescribing Person/Phone*	Pos or Neg Side Effects?
Med 1							
Med 2							
Med 3							
Med 4							
Med 5							
Med 6							

*We would like to ask for a release of information to speak with each client's prescribing health care professional to coordinate care.