Gina Kramer, MFT
Therapy for Children, Adolescents and Adults
1434 Third Street, Suite #3A • Napa, California 94559 • 707-334-4704

CHILD & ADOLESCENT
NEW CLIENT INTAKE INFORMATION

Thank you for taking the time to complete the following form.
If you have any questions about any part of this form, feel free to discuss them with me during our first visit.

Today's date: _____

Child's Name: _____

Date of Birth: _____ **Age:** _____

Race/ethnicity: _____

Child's parent/custodian/guardian(s) is/are: _____

_____

Child's Home Address: _____

City: _____State: _____Zip Code: _____

Home Telephone: _____ Other Phone (specify type): _____

Is it OK to contact you/child at home? ☐ YES or ☐ NO OK to leave a message? ☐ YES or ☐ NO

Email address: _____

Special instructions? _____

Emergency Contact Name: _____Relationship to Child: _____

Home Telephone: _____Other Phone (specify type): _____

Person(s) completing this form: _____

Who suggested that you contact me? _____

MOTHER'S INFORMATION:

Mother's name:_____ Date of birth:_____

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Phone:_____ Other Phone: _____

Address: (If different from the child) _____

Highest Grade Completed: _____

Marital/relationship status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment status (Check all that apply):

☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed

If/When employed, what type of work does mother do? _____

Current employer is: _____

Years on Current Job: _____ Business Phone: _____

Is it OK to contact mother at work? ☐Yes or ☐ NO OK to leave a message? ☐YES or ☐ NO

FATHER'S INFORMATION:

Father's name: _____ Date of birth: _____

Phone:_____ Other Phone: _____

Address: (If different from the child) _____

Highest Grade Completed: _____

Marital/relationship status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment status (Check all that apply):

☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed

If/When employed, what type of work does father do? _____

Current employer is: _____

Years on Current Job: _____ Business Phone: _____

Is it OK to contact father at work? ☐Yes or ☐ NO OK to leave a message? ☐YES or ☐ NO

STEPMOTHER'S INFORMATION:

Stepmother's name: _____ Date of birth:_____

Phone:_____ Other Phone: _____

STEPFATHER'S INFORMATION:

Stepfather's name: _____ Date of birth:_____

Phone:_____ Other Phone: _____

REASON FOR SEEKING TREATMENT:

Please briefly describe the problems your child is experiencing: _____

What has happened to cause you to seek help NOW? _____

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What do you hope to be able to do or achieve as a result of treatment? _____

What do you consider to be other stresses in your child's life currently? _____

HISTORY OF THE PROBLEM:

When did your child first start experiencing the problem(s) that brought you to my office today? _____

How often does the problem occur? _____

How long does it last? _____

Does your child have any thoughts of harming him/herself? ☐Yes or ☐ No

Has your child ever attempted to harm him/herself? ☐Yes or ☐ No

If yes, please explain: _____

Does your child have any thoughts of harming someone else? ☐Yes or ☐ No

Has your child ever attempted to harm someone else? ☐Yes or ☐ No

If yes, please explain: _____

Has your child ever been hospitalized for emotional/behavioral problems? ☐Yes or ☐ No

If yes, when/where was this: _____

Has your child been prescribed medications to control emotional/behavioral issues? ☐Yes or ☐ No

If yes, please list medications, when prescribed, and by whom: _____

To your knowledge, has your child experimented with alcohol/drugs? ☐Yes or ☐ No

Are you concerned that your child might have or be developing a problem with alcohol or drugs? ☐Yes or ☐ No

If yes, please explain: _____

FAMILY INFORMATION & HISTORY:

Number of Person's Living in Household: (including you _____/ Please List Below:

Name:	***Relationship:***	***Age:***

Has your child ever experienced any parental separations, divorces, or death? ☐Yes or ☐ No

If yes, when? _____How old was the child at the time? _____

Please describe the circumstances: _____

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If parents are separated or divorced, who has custody of this child? _____

How often does the other parent see this child: ☐ Weekly or more often ☐ Once or twice a month

☐Few times a year ☐Never

How well do you feel that you are able to co-parent? _____

Has your child or anyone in the immediate family received psychological services before? ☐Yes or ☐ No

If so please complete:

Name /Relationship:	***Name of Provider (if known):***	***Reason for Treatment:***	***Was it helpful?***
_____	_____	_____	☐Yes or ☐ No
_____	_____	_____	☐Yes or ☐ No
_____	_____	_____	☐Yes or ☐ No

Did you feel therapy was helpful? Please explain: _____

Is there any significant mental health history in the family? If so, please explain: _____

Has anyone in your family ever attempted or committed suicide? ☐Yes or ☐ No

If yes, please briefly explain (who/when): _____

FAMILY HEALTH

Have any family members had any of the following? (PLEASE CHECK IF YES & SPECIFY RELATIONSHIP TO CHILD)

☐ Cancer	☐ Heart Disease	☐ Mental illness
☐ Severe Head/Neck Injury	☐ Alcohol/drug abuse	☐ Physical disability
☐ Tourette's Syndrome	☐ High blood pressure	☐ Energy level
☐ Cerebral Palsy	☐ Kidney disease	☐ Mental retardation
☐ Diabetes	☐ Behavior disorder	☐ Stroke
☐ Food Allergies	☐ Migraine headaches	☐ Attention Deficit/Hyperactivity Disorder
☐ Nervousness	☐ Tuberculosis	☐ Sleep difficulties
☐ Seizures/Epilepsy	☐ Alzheimer's disease	☐ Tics
☐ Reading problems	☐ Other learning difficulties	☐ Anxiety
☐ Speech/language problems	☐ Sickle cell anemia	☐ Bipolar disorder
☐ Multiple Sclerosis		

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Other significant health or emotional problem/s: _____

What kinds of stressful events have any of your family members experienced recently? _____

Is there or have there been conflicts between parents/siblings/parent-child? _____

Has your child or anyone in your family experienced trauma? ☐Yes or ☐ No
If yes, please explain: _____

What type of discipline is used within the home? _____

How does the child respond to the discipline? _____

How often does your family do something together? _____

CHILD'S EDUCATION:

Current School: _____ Phone Number: _____

Teacher: _____ Grade: _____

Does your child have an active IEP? ☐Yes or ☐ No 504 Plan? ☐ Yes or ☐ No

If yes, what is the focus? _____

Describe any difficulties or problems your child is having in school: _____

CHILD'S DEVELOPMENTAL HISTORY:

Was this a planned pregnancy? ☐Yes or ☐ No

Did his/her mother receive prenatal care? ☐Yes or ☐ No

Number of previous pregnancies/miscarriages: _____ Number of children/siblings: _____

Describe any complications that occurred during the pregnancy: _____

What drugs/medications were used during the pregnancy? _____

At the time of the child's birth, what was the: Mother's age? _____ Father's age? _____

Length of pregnancy: _____ weeks Birth weight: _____ Length of labor: _____

Child's condition at birth: _____

Length of stay in hospital: Mother _____ days Child _____ days

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Mother's condition at birth: (Please include any concerns with regards to Postpartum Depression)

_____

Is this child adopted? Or has your family had an adoption history? ☐Yes or ☐ No

If yes, please provide adoption history: _____

Was this child Breastfed or Bottle Fed? _____

If breastfed when was she/he weaned?

Were there any early complications with regards to feeding? _____

Do you have any current concerns about your child's eating patterns? _____

If so, please explain: _____

How would you describe your child's temperament as an infant? _____

At what approximate age was this child toilet trained? Days: _____ Nights: _____

Do you have any concerns about your child's toilet training at this time? _____

If so, please describe your concerns: _____

Describe your child's sleep patterns and/or any concerns you may have: _____

Did your child experience any language difficulties? ☐Yes or ☐ No

If yes, describe: _____

Do you have any current concerns about your child's speech or language? _____

If yes, please describe: _____

Did your child meet other developmental milestones within an average range? ☐Yes or ☐ No

If no, please describe: _____

As a young child, did your child have problems getting along with others? _____

If yes, please describe: _____

Were there other problems experienced during the child's first two years of life? _____

If yes, describe: _____

CHILD'S MEDICAL HISTORY AND CARE

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Child's physician: _____ **Telephone**: _____
Address _____

How often does this child see a doctor? _____Date of last visit: _____

Is your child currently on any medication? ☐Yes or ☐ No
If yes, indicate type and reason: _____

Does your child have any history of the following? (Please CHECK all that apply)

☐ Hospitalizations	☐ Headaches	☐ Eye, Ear, Nose & Throat Problems
☐ Surgeries	☐ Allergies/Food Allergies	☐ Digestive Disorder
☐ High Fevers	☐ Stomach/Intestinal Issues	☐ Head Injuries/Seizures
☐ Serious Accidents	☐ Loss of Consciousness	☐ Sensory Processing Issues
☐ Serious Illness		

Please elaborate any details of the conditions you checked above:

_____

CHILD'S INTERESTS AND ACTIVITIES:

Is this child involved in any extracurricular activities, such as sports, dance or music programs? ☐Yes or ☐ No

Clubs or religious organizations? ☐Yes or ☐ No

Please describe your child's strengths and positive characteristics: _____

When do you see your child the happiest? _____

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SYMPTOM CHECKLIST

(Please CHECK any symptoms that are a concern):

☐ Sleep Problems	☐ Morbid thoughts	☐ Swears
☐ Lack of interest in activities	☐ Excessive worry / Fearfulness	☐ Frequent tantrums
☐ Unassertive	☐ Anxiety or panic attacks	☐ Resistive to change
☐ Fatigue/low energy	☐ Social fears / shyness	☐ School refusal
☐ Concentration problems	☐ Separation problems	☐ Perfectionism
☐ Appetite/weight changes	☐ Bedwetting / Soiling	☐ Odd hand / motor movements
☐ Withdrawal	☐ Headaches or Stomachaches	☐ Hallucinations
☐ Can't sit still	☐ Odd beliefs / fantasizing	☐ Destructive
☐ Short attention	☐ Lying	☐ Fire setting
☐ Forgetful/memory problems	☐ Running away	☐ Hurting others / fighting
☐ Aggressive behavior	☐ Alcohol/Drug use	☐ Trouble with the law
☐ Lack of interest in peers	☐ Argumentative / Defiant	☐ Truancy, skipping school
☐ Picked on/Bullied by peers	☐ Blames others for mistakes	☐ Easily annoyed / annoys others
☐ Suicidal thoughts or threats	☐ Nightmares	☐ Short tempered
☐ Mood swings	☐ Stealing	☐ Running away
☐ Depression	☐ Problem completing schoolwork	☐ Acts as if has no fear
☐ Changed level of activity	☐ Difficulty following rules	☐ Angry and resentful
☐ Cries easily	☐ Discipline problems	☐ Irritable
☐ Talks excessively / Interrupts	☐ Impulsive	☐ Other
☐ Easily distracted		

Was there any other information you feel is important and wasn't asked about? If so, please explain:

_____

_____

Thank you so very much for your time completing this form!

Gina Kramer, MA, LMFT