

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:

| <i>Name:</i> | <i>Relationship:</i> | <i>Age:</i> |
|--------------|----------------------|-------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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? |
|----------------------------|---|------------------------------|---|
| _____ | _____ | _____ | <input type="checkbox"/> Yes or <input type="checkbox"/> No |
| _____ | _____ | _____ | <input type="checkbox"/> Yes or <input type="checkbox"/> No |
| _____ | _____ | _____ | <input type="checkbox"/> Yes or <input type="checkbox"/> No |

Did you feel therapy was helpful? Please explain: _____

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

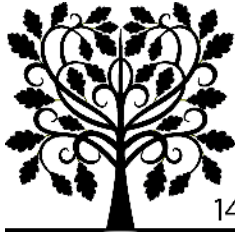
Has anyone in your family ever attempted or committed suicide? Yes or No

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)

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

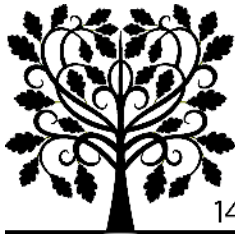
What drugs/medications were used during the pregnancy? _____

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: _____

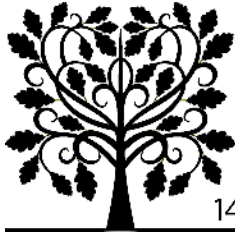
As a young child, did your child have problems getting along with others? _____

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)

| | | |
|--|--|---|
| <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Headaches | <input type="checkbox"/> Eye, Ear, Nose & Throat Problems |
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> Allergies/Food Allergies | <input type="checkbox"/> Digestive Disorder |
| <input type="checkbox"/> High Fevers | <input type="checkbox"/> Stomach/Intestinal Issues | <input type="checkbox"/> Head Injuries/Seizures |
| <input type="checkbox"/> Serious Accidents | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Sensory Processing Issues |
| <input type="checkbox"/> Serious Illness | | |

Please elaborate any details of the conditions you checked above:

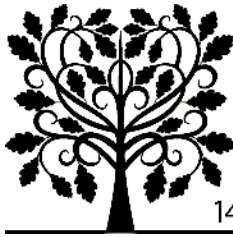
CHILD'S INTERESTS AND ACTIVITIES:

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):

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