Cleveland Integrative Counseling Intake Form

Welcome to Cleveland Integrative Counseling. Please complete the following paperwork before your initial intake appointment with your therapist. **We request that an electronic version be returned to our office 24 hours before your scheduled intake.** This allows your therapist time to review your concerns and prepare for your appointment so that your time together is used in the most efficient manner. Please also bring your original copy to the appointment.

As you glance through the following pages, do not be concerned by the length of the intake. We have structured the document in a way that permits for you to elaborate upon your responses should you find it helpful to better understanding your child. If you come upon a section and are unsure regarding your response, do not struggle, we will go over your responses together during your child's first appointment. Similarly, you may also find that you will skip entire sections, and that too, is okay.

At Cleveland Integrative Counseling, we do not fail to appreciate the vulnerability and strength that it takes to seek help, and truly look forward to partnering with you and your child to create positive outcomes. If you have any questions, please contact our office.

23240 Chagrin Blvd.
Commerce Park IV, Suite 101
Beachwood, OH 44122

(216) 600 -8008
beth@clevelandint.com

BACKGROUND/DEMOGRAPHIC INFORMATION

Child's Name: _____ Today's Date: _____

Date of Birth: _____ Gender: _____ Age: _____

Home Address: _____

(Street, State, Zip Code)

Home Phone: ( ) _____ Work Phone: ( ) _____Ext:_____

School: _____ Phone: ( ) _____

School Address: _____

(Street, State, Zip Code)

Grade in School: _____ Teacher's Name: _____

Person Completing Form: _____ Date: _____

(Name) (Relationship)

Child lives with (check all the applies):___ both biological parents ____ mother ____ father ____ other*

*Other: _____

Parental Marital Status: □ Married □ Divorced □ Never Married □ Separated □ Widowed

If parents are divorced, describe custody arrangements:_____

_____

_____

_____

Does the non-custodial parent know your child is engaging in services: ____ YES ____ NO ____ N/A

Emergency contact person (other than parent): _____

Relationship to child: _____

Phone number _____

Parent/Guardian Information (include any Step-Parent(s) information, if applicable):

Name: _____ Age_____

Relationship to child: _____

Employer _____ Occupation _____

Work Hrs/wk. _____ Can you be contacted at work by phone? **Yes No**

Contact Information- (Please Check Preferred Contact Method):

□ Phone: ___________________________________ □ Cell Phone_________________________________

□ Work ____________________________________ □ Email _____________________________________

Cultural/Religious Considerations: ____

Name: ____ Age____________

Relationship to child: ____

Employer ____ Occupation ______________________

Work Hrs./wk. __________________________________ Can you be contacted at work by phone? Yes No

Contact Information- (Please Check Preferred Contact Method):

□ Phone: ___________________________________ □ Cell Phone_________________________________

□ Work ____________________________________ □ Email _____________________________________

Cultural/Religious Considerations: ____

Name: ____ Age__________________

Relationship to child: ____

Employer ____ Occupation ______________________

Work Hrs./wk. __________________________________ Can you be contacted at work by phone? Yes No

Contact Information- (Please Check Preferred Contact Method):

□ Phone: ___________________________________ □ Cell Phone_________________________________

□ Work ____________________________________ □ Email _____________________________________

Cultural/Religious Considerations: ____

Name: ____ Age____________

Relationship to child: ____

Employer ____ Occupation ______________________

Work Hrs./wk. __________________________________ Can you be contacted at work by phone? Yes No

Contact Information- (Please Check Preferred Contact Method):

□ Phone: _____ □ Cell Phone_____

□ Work _____ □ Email _____

Cultural/Religious Considerations: _____

Please list others living in custodian parent's home, including names, ages, and relationship to child:

_____

_____

_____

_____

Please list others living in non-custodian parent's home, including names, ages, and relationship to child (leave blank is N/A):

_____

_____

_____

_____

Current Concerns

Who referred you for counseling?

_____

_____

Has your child been seen by a different counselor in the last 90 days? Yes No

If yes, who? _____

What is your main concern about your at this time?

_____

_____

_____

When did this problem begin?

_____

_____

_____

What made you decide to seek treatment for your child?

_____

_____

_____

How does this concern affect your child in the following areas?

1. Emotional Functioning: _____

   _____

   _____

2. Relationships (friends, socially):_____

   _____

   _____

3. Concentration/Thinking:_____

   _____

   _____

4. Physical Symptoms (headaches, stomachs, etc.): _____

   _____

   _____

5. General Behavior: _____

   _____

   _____

6. School: _____

   _____

   _____

What goals do you have for therapy for your child?

_____

_____

_____

Do you have any additional concerns?

_____

_____

_____

What are your child's strengths (sports, talents, personal traits)?

_____

_____

_____

MEDICAL/DEVELOPMENTAL HISTORY

PREGNANCY, BIRTH & EARLY DEVELOPMENT

Circle any items that apply to Mother's pregnancy, birth and early infancy:

Pregnancy		Birth		Infancy
None		Normal Delivery		Feeding Problems
High Blood Pressure		Difficult Delivery		Sleep Problems
Bed Rest		Cesarean Delivery		Colic
Alcohol Use		Complication*		Other*
Drug Use		_____		_____
Cigarette Use				
Wetting Bed				
Swallowing				
Other*: _____				

How many weeks was child at birth: _____ Birth Weight: _____

If there were any problems during delivery, please describe:

_____

_____

_____

If there was any special care given to the infant after delivery (for example: Neonatal intensive care, placement on respirator) please describe:

_____

_____

_____

If your child had any medical problems in the first few weeks of life, please describe:

_____

_____

_____

Did mother experience any post-partum depression or anxiety following the birth? Yes No

Please indicate the age your child (approximately) did the following:

_____ walked without support _____ spoke in single words _____ combined two or three words

If you feel that your child's early development (ages 1-5) was delayed in any way (for example: speech & language, motor skills, social behavior) please describe:

_____
_____
_____

Current Medical/Psychiatric History

Primary Care Physician: _____Phone:_____
Psychiatrist (if any): _____Phone:_____

List any other medical providers involved in your child's care (**doctor, psychologist, social worker, counselor, speech therapist, special tutor, or other specialist)**:

_____
_____
_____
_____
_____
_____

List any current medical conditions:

_____
_____
_____

List any medication, include dosage and reason for use:

_____
_____
_____

List any medications previously taken for psychiatric concerns, include dosage and reason for stopping:

_____
_____
_____

List any known allergies:

_____

If your child has/ had any of the following medical problems, please check and describe below:

Condition	Age	Condition	Age
Poor Growth		Seizures	
Hospitalization/Operations		Neurological Condition	
Condition/Disease		Abuse (Physical or Sexual)	
Poisoning		Head Injury	
Loss of Consciousness		Lead Poisoning	
Other:*			

*Other:

_____

_____
_____

CURRENT HEALTH

Describe current physical health: Good Fair Poor

Date of child's last physical exam: _____

How would you describe your child's eating patterns? _____
_____
_____

Any changes in appetite? **Yes No** Weight changes? **Yes No** Energy Level changes? **Yes No**

Please identify if your child had/has any of the concerns below, if so, please indicate age:

Concern	Age	Concern	Age
Vision		Walking	
Movement of Eyes		Talking	
Hearing		Funny Feeling in Body (e.g. numbness, tingling)	
Tics/Twitching of Face/Body		Decreased Strength	
Staring Spells		Noticeable Change in Appetite	
Soiling Bed		Swallowing	
Wetting Bed		Other*	

*Other:
_____
_____
_____

SOCIAL EMOTIONAL BEHAVIORS:

If Present, Indicate Yes:		If Present, Indicate Yes:	
	Normal Social Interaction		Drug Use
	Very Shy		Alcohol Abuse
	Isolated Self		Stealing
	Inappropriate sexual behavior		Often Sad
	Dominating other		Violent Temper
	Distrustful		Immature
	Impulsive		Hyperactive
	Indecisive		Extreme Worrier
	Challenging Friendships		Disobedient
	Self-Injurious Behavior		Anxious
	Fire Setting		Easily Distracted
	Frequent Daydreamer		Other*

*Other:

_____

_____

_____

CURRENT OBSERVATIONS OF YOUR CHILD:

Symptom	Yes	No	Symptom	Yes	No
Inattention			Hyperactive		
Easily Distracted/Bored			Cyclical Changes in mood		
Messy, disorganized			Rigid, inflexible thinking		
Forgetful			Difficulty reading social cues		
Impulsive			Panic Attacks		
Accident Prone			Social Anxiety		
Risk taking			Performance Anxiety		
Lazy unmotivated			Obsessive Compulsive Behaviors		
Trouble completing tasks			Change in Sleep		
Needs constant reminders			Trouble Falling Asleep		
Fidgety or restless			Trouble Staying Asleep		
Losing Interest in Things			Waking up Too Early		
Change in Memory/Concentration			Feelings of hopelessness		
Frequent Anger Episodes			Difficulty with change/transition		
Other*					

*Other:

_____

_____

_____

How does your child presently manage stressful situations?

_____

_____

_____

FAMILY PSYCHIATRIC & SOCIAL HISTORY

What is the relationship like between parents/major caregivers (i.e. Do parents get along with each other? If divorced and in a new relationships, what is the relationship dynamic?) _____

_____

_____

_____

Has your child ever witnessed domestic violence? If yes, describe: _____

_____

_____

What is your child's relationship like with each parent or caregiver? _____

_____
_____
_____
_____

How do you discipline your child and is it effective? _____
_____
_____

How do you promote good behavior? _____
_____
_____

What is the household climate like? Conflictual? Warm? Permissive? _____
_____
_____

How is your child's behavior with each sibling? _____
_____
_____
_____
_____

Do any immediate family members (parents or siblings) have any medical or developmental conditions? If so, please indicate the level of impact that this has on the family from 1-5 (1 = little impact; 5 = significant impact):

_____
_____
_____
_____
_____
_____
_____
_____

Please indicate if there are any family members who have any of the difficulties listed below. Also indicate the relationship to the child of the family members with difficulties.

Condition	Yes	No	Relationship to Child
Trouble learning to read or spell			
Trouble with arithmetic			
Speech and language problems			
Repeated grade(s)			
Hyperactive or attention problems			
Developmental Disability			

Alcoholism or drugs			
Problems with the law			
ADHD			
Anxiety			
Schizophrenia			
Postpartum Depression			
Bipolar Disorder			
Mania			
Vocal Tic			
Skin Picking/Hair Pulling			
Eating Disorder			
Autism Spectrum Disorder			
Other*: _____			

*Other:

_____

_____

_____

Have any family member's experienced similar symptoms as your child: _____

_____

_____

Please describe your family activities (i.e. Travel, board games, sports, etc.): _____

_____

_____

Does your family have any religious or cultural involvement? If yes, please describe, including your child's involvement? _____

_____

_____

Do you feel that your family has a strong support system outside of your immediate family? : _____

_____

_____

Is there anything else about your family that is important for us to know? : _____

_____

_____

SCHOOL HISTORY

Please tell us where your child has gone to school. Begin with the first year of school, preschool, or daycare outside of the home. List each school on a separate line.

Year Age Grade(s) Name of School City/District

_____

_____

_____
_____
_____
_____
_____

Has your child received any special services in school (e.g. IEP, 504, academic accommodation)?

_____
_____
_____

Has your child ever been suspended, expelled or received a detention? If so, please describe: _____

_____
_____

Describe your child's academic performance: _____

_____
_____

Was your child every held back? If yes, what grade and why? _____

_____
_____

Has your child been identified as having a learning disability? If yes, by whom and what type of disability? _____

_____
_____

Is homework completion a problem? **Yes No**. If so how often? _____

_____
_____

Please indicate if your child encounters the following challenged:

	Yes	No
Forgets to turn in homework		
Write down assignment		
Bring books home from school		
Make careless mistakes		
Take too long on assignments		

Social Activities & Friendships

List some of your child's favorite activities and interests? _____

_____
_____

Is your child involved in any sports, clubs, or other extracurricular activities? If so, please describe the amount of time involved, including practices and commute to/from, and time of day/day of week that such practices occur: _____
_____
_____

If your child is engaged in sports, how do they handle losing or teammates not preforming as expected?
_____
_____
_____

Does your child regularly engage with friends? Can you describe the quality of this friendship:
_____
_____
_____

Does your child engage with friends outside of the school setting: **Yes** **No**

Is it hard for your child to make/keep friends? **Yes** **No** If yes, please describe: _____
_____
_____

Has your child been involved in dating relationships? **Yes** **No** If yes, please describe: _____
_____
_____

Is your child sexually active? **Yes** **No** **Don't Know**

Does your child have any concerns about sexual orientation: **Yes No** Gender Identity: **Yes No**

LEGAL INVOLVEMENT/SUBSTANCE ABUSE HISTORY

Has your child had any involvement with the court system: Yes No
If yes, please indicate the reason for court involvement, if charges were filed, and if they are on probation: _____
_____
_____

Has your child experimented with and/or do you have any reason to believe that your child has tried with any of the following substances

Substance	Yes	No	Amount, Frequency, and Age of First Use:
Alcohol			
Marijuana			
Tobacco			
Cocaine			
Inhalants			
Stimulants			
Other*			

*Other:

_____

_____

_____

Has your child ever been in treatment for substance abuse: Yes No

Is there a family history of substance abuse? If so, please describe: _____

_____

_____

Does your child have a preoccupation with fire, matches? **Yes No**

Does your child have a history of animal cruelty? **Yes No**

Please list any additional concerns, topics not address or otherwise below:

_____

_____

_____

_____

_____

_____

Once complete, please return an electronic copy of this document to our office and bring the original to your intake appointment.

We request that this initial intake be submitted <u>at least</u> 24 hours before your scheduled initial intake.

We truly value the time and effort put into completing this document, and look forward to partnering with you for the betterment of your child.

Please submit the document to beth@clevelandint.com

For questions, please call: 216 600 8008