RICHMOND CREATIVE COUNSELING

Child Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please submit this paperwork before your first appointment.

For Psychiatric Appointments, please bring any available medical records and prescription history to your first appointment.

Legal Name: _____
(Last) (First) (Middle)

Is this the same name on your insurance card? ☐ Yes ☐ No, name on insurance: _____

Preferred Name If Different From Above/ Nickname: _____

Birthdate: _____ Age: _____ Parent/ Guardian SSN: _____

Address: _____
(Street and Number) (City/ State/ Zip)

Name of Parent/ Legal Guardian: _____
(Last) (First) (Middle Initial)

Home Phone: _____ Messages ok? ☐ Yes ☐ No

Cell/ Other Phone: _____ Messages ok? ☐ Yes ☐ No

Guardian's Email: _____

Emergency Contact Name (*required*): _____ Relationship: _____

Emergency Contact Number: _____

Referred By: _____

Gender Identity: ☐ Woman ☐ Man ☐ Trans MTF ☐ Trans FTM ☐ Genderqueer ☐ Other: _____

Sex Assigned At Birth (Administrative Sex): ☐ Female ☐ Male ☐ Intersex ☐ Other: _____

Pronouns: ☐ She/ Her ☐ He/ His ☐ They/ Them/ Their ☐ Zie/ Hir ☐ Other: _____

General Health & Mental Health Information

1. How would you rate your child's current physical health? Please choose one:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems your child is currently experiencing: _____

_____

2. How would you rate your child's current sleeping habits? Please choose one:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems your child is currently experiencing: _____

_____

3. How many times per week does your child participate in physical activity? _____

In what types of activities do they participate? _____

4. Please list any difficulties your child may experience with appetite or eating patterns: _____

_____

5. Is your child currently experiencing overwhelming sadness, grief, or depression? ☐ No ☐ Yes, approximately how long?:

_____

6. Is your child currently experiencing anxiety, panic attacks, or have any phobias? ☐ No ☐ Yes, when did this begin?:

_____

7. Is your child currently experiencing any chronic pain? ☐ No ☐ Yes, please describe:

_____

8. Has your child engaged in any alcohol or drug use to your knowledge? ☐ No ☐ Yes ☐ Unsure

If yes, please describe: _____

9. How often does your child exhibit "temper tantrums" or behavioral issues?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Please describe: _____

_____

11. What significant life changes or stressful events has your child experienced recently? _____

_____

_____

12. Have your child previously received any type of mental health services (therapy, psychiatric care, etc.)?

☐ No ☐ Yes, previous therapist/ psychiatric provider: _____

13. Is your child currently taking any prescribed medications?

☐ No ☐ Yes, please list: _____

14. Has your child previously been prescribed psychiatric medications?

☐ No ☐ Yes, please list and include dates: _____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.).

Alcohol/ Substance Abuse: ☐ No ☐ Yes: _____

Anxiety: ☐ No ☐ Yes: _____

Family Mental Health History (continued)

Depression: ☐ No ☐ Yes: _____

Domestic Violence: ☐ No ☐ Yes: _____

Eating Disorders: ☐ No ☐ Yes: _____

Obesity: ☐ No ☐ Yes: _____

Obsessive Compulsive Disorder: ☐ No ☐ Yes: _____

Schizophrenia: ☐ No ☐ Yes: _____

Suicide Attempts: ☐ No ☐ Yes: _____

Additional Information

1. How would you rate the current stress level in the family home? ☐ Very Stressful ☐ Stressful ☐ Neutral ☐ Stress-free

If stressful, what contributes to the stress? _____

2. Name of child's school & current grade: _____

How would you rate your child's academics (grades): ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

How would you rate your child's behavior in school: ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

3. Is your family spiritual or religious? ☐ No ☐ Yes, please describe below

_____

4. What do you consider to be some of your child's strengths?

_____

5. What do you consider to be some of your child's weaknesses?

_____

6. What would you like your child to accomplish out of their time receiving services?

_____

7. What additional information would you like your provider(s) to know about your child?

_____

For Psychiatric Appointments Only

1. Do you have a preferred pharmacy? ☐ No ☐ Yes

_____

(Pharmacy Name) (Location)

2. Does your child have a Pediatrician? ☐ No ☐ Yes

_____

(Provider/ Practice Name) (Phone Number)

3. Do your child have any allergies (food, medical/ drug, environmental)? ☐ No ☐ Yes, please describe below

_____