COVA
COASTAL VIRGINIA
COUNSELING • MEDIATION

CHILD INTAKE

CLIENT INFORMATION

Today's Date ___/___/___ Referred by: __________________ Client's Name: ______________________Date of Birth: ___/___/___ Age: _______

Client's Address: ____ City: _______________________________ State:____ Zip:_____________

Phone (Home): ______________________ (work): _____________________ (cell): ______________________ (other): ______________________

School: _______________________________________ Grade level: _________ Teacher's name: ____

Does the child attend church: ☐ Yes ☐ No Child's church: ____

Child's custodian/guardian(s) are: ____

MOTHER'S INFORMATION

Mother's name: ____ Date of birth: _____________________ Age: ___________

Mother's Address: ____ City: _______________________________ State:____ Zip:_____________

Phone (Home): ______________________ (work): _____________________ (cell): ______________________ (other): ______________________

E-mail: ___________________________________ Occupation: _________________________Employer: __________________________________

Marital Status: ☐ Married ☐ Engaged ☐ Widowed ☐ Divorced ☐ Separated ☐ Live with partner ☐ Remarried

If remarried, name of spouse:_____________________________ Do you attend church? ☐ Yes ☐ No Church Name: _________________________

FATHER'S INFORMATION

Father's name: ____ Date of birth: _____________________ Age: ___________

Father's Address: ____ City: _______________________________ State:____ Zip:_____________

Phone (Home): ______________________ (work): _____________________ (cell): ______________________ (other): ______________________

E-mail: ___________________________________ Occupation: _________________________Employer: __________________________________

Marital Status: ☐ Married ☐ Engaged ☐ Widowed ☐ Divorced ☐ Separated ☐ Live with partner ☐ Remarried

If remarried, name of spouse:_____________________________ Do you attend church? ☐ Yes ☐ No Church Name: _________________________

EMERGENCY CONTACT

Name: ____ Phone: ___________________________ Relation: _____________________________

MENTAL HEALTH TREATMENT

Has your child ever seen a therapist before? ☐ Yes ☐ No Therapist/Counselors Name: ____

Have you seen a Psychiatrist or Psychiatric Nurse Practitioner? ☐ Yes ☐No Psychiatrist / PNP Name: ____

Have you ever had a mental health diagnosis? ☐ Yes ☐ No If yes: ____

MEDICAL AND INSURANCE

Primary Care Physician: ____ Office phone: ______________________ Fax: ______________________

Address: ____ City: _______________________ State: _________ Zip: _________________________

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Insurance Information (required to bill insurance):

Insurance Carrier: ____ Policy #: ____

Name of policy holder: ______________________ Policy holder's date of birth: _______________ Relationship to Patient: _________________

Policy holder's address and phone number (if different from client):

Policy Holder's Address: _______________________________________ City: ____________________________ State:____ Zip:____________

Phone (Home): _____________________ (work): ____________________ (cell): _____________________ (other): ______________________

FOR TRICARE ONLY

Active member's Last name: __________________________________ Active member's first and middle names: __________________________

Active member's social security number: ________________________ Client's Primary Care Physician: ___________________________________

FAMILY COMPOSITION

Who currently reside in the same house as the client? Please include family members as well.

NAME	AGE	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		

CURRENT MEDICATIONS

Name of Medication	Dosage	Frequency	Treatment for

SCHOOL PERFORMANCE

What subjects does your child consistently do well in? ____

What subjects does your child consistently do poor in? ____

Grade tend to be: ☐ A ☐ A-B ☐ B ☐ Some C ☐ All C ☐ C and below Is your child expected to pass school this year? ☐ Y ☐ N ☐ Unsure

How does your child typically handle homework?

☐ Does homework on their own ☐ Needs my help to do homework ☐ Has to be constantly reminded to do homework ☐ Forgets assignments

☐ Refuses to do homework ☐ Tries to do homework, but struggles to understand

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CHILD INTAKE

CHILD'S INTEREST AND STRENGTHS

- ☐ Catching and throwing a ball
- ☐ Dancing
- ☐ Building models
- ☐ Working with electronics
- ☐ Reading for pleasure
- ☐ Caring for pets / animals
- ☐ Understanding what he / she reads
- ☐ Learning about science
- ☐ Memorizing things for school
- ☐ Other: ____________________________
- ☐ Running fast
- ☐ Art work
- ☐ Building things
- ☐ Telling stories
- ☐ Using his / her imagination
- ☐ Reading fast
- ☐ Handwriting
- ☐ Learning about history
- ☐ Singing
- ☐ Playing an instrument
- ☐ Working with machines
- ☐ Writing stories / poems
- ☐ Remembering where to find things
- ☐ Figuring out new reading words
- ☐ Learning new spelling words
- ☐ Using a computer
- ☐ Playing video games
- ☐ Playing a particular sport

PARENTAL ASSESSMENT OF CHILD

FEELINGS:

- ☐ Restless
- ☐ Angers easily
- ☐ Bored easily
- ☐ Fearful
- ☐ Reading for pleasure
- ☐ Sad
- ☐ Lacks remorse
- ☐ Irritable
- ☐ Shows feelings that concern you
- ☐ Using his / her imagination
- ☐ Cries easily
- ☐ Sullen
- ☐ Overly guilty
- ☐ Remembering where to find things

BEHAVIOR:

- ☐ Has problems in school
- ☐ Refuses to talk
- ☐ Involved in sexual activity (ages 10-17)
- ☐ Steals
- ☐ Lack interest in things usually enjoyed
- ☐ Does things that seem strange for age
- ☐ Overactive
- ☐ Threatens or harms other children
- ☐ Sets fires
- ☐ Plays sexual games with others, toys
- ☐ Destroys possessions or properties
- ☐ Has been in trouble with police
- ☐ Threatens or harms animals
- ☐ Hurts himself / herself

SOCIAL INTERACTION:

- ☐ Withdraws
- ☐ Defiant
- ☐ Difficulty keeping friends
- ☐ Often gets in fights
- ☐ Concerned about how child interacts with you
- ☐ Makes little to no eye contact
- ☐ Argumentative
- ☐ Severe or frequent tantrums
- ☐ Doesn't want to go to school
- ☐ Concerned how child interacts with other family members
- ☐ Clings to you often
- ☐ Difficulty making friends
- ☐ Picks on others
- ☐ Prefers to be alone
- ☐ Concerned with how child interacts with peers or playmates

THINKING:

- ☐ Daydreams often
- ☐ Has difficulty remembering things
- ☐ Decline in schoolwork/grades
- ☐ Concerned about child's thinking process
- ☐ Has strange thoughts
- ☐ Frequently confused
- ☐ Talks of death often
- ☐ Blames others for misdeeds or thoughts
- ☐ Difficulty trusting others
- ☐ Distracted easily
- ☐ Talks of suicide often
- ☐ Sees or hears things that are not there

PHYSICAL PROBLEMS:

- ☐ Lack of energy
- ☐ Wet pants
- ☐ Refuses to eat
- ☐ Accident prone
- ☐ Vomits often
- ☐ Soils pants
- ☐ Has stomach aches often
- ☐ Has lost or gained significant amount of weight
- ☐ Sneaks food
- ☐ Uses laxatives
- ☐ Has headaches
- ☐ Has sleeping problems; nightmares, sleepwalking, early waking, night waking

PRESENTING PROBLEM

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CHILD INTAKE

Please describe what brings you in here today?

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