Lindsay A. Solomon, Psy.D.
Licensed Psychologist

Child Client Intake Form

Date: ___________________

Child's Name: ____________________________________ **Date of birth:** _______________________

Age: ______________ **Gender:** ________________ **Ethnicity:** ______________________________

Parent(s)/Caregiver(s): _____________________________________**Age(s):** _________________

Home street address: ____

City: ____________________ **State:** _____ **Zip:**_________ **County:**___________________________

Name of Employer: ____

Home Phone: ________________________ **Work Phone:** ___________________________________

Cell Phone: ____

Email: ____

Calls and emails will be discreet, but please indicate any restrictions and/or preferences for communications: ____

Is this the contact information for all custodial parents/caregivers of this child? Yes ❑ No ❑
If no, please provide the name and contact information of additional custodial parents/caregivers:

____

____

Parents' or Caregivers' marital status:
Married/living together ❑
Divorced ❑
Never Married ❑
Other ❑

Please list the names and relations of people who currently live with the child

Names	M/F	Age	Relationship

Child's Name: ______________________________

Please briefly describe your current concern(s) about your child: ______________________

How long have you had these concerns? ______________________

What are your goals for therapy? ______________________

Academic Information

Child's School: ______________________ Grade: ________

Has your child repeated any grades? If yes, which grade? ________________

Average grades: ________________ Changes in school performance? ______________

Briefly describe any school behavior or academic concerns: ______________________

Has your child been referred for special services in school (evaluation, IEP, speech, etc.)?

Does your child make and keep friends easily? ❑ Yes ❑ No
Does your child get along with siblings/family members? ❑ Yes ❑ No
Are there people that your child avoids? ❑ Yes ❑ No

If yes, please explain:

Is your child involved in extracurricular activities?

Medical Information

Has your child had any major illnesses, injuries or operations? Any allergies or asthma? Please describe: ____

____

Has your child experienced any sleep or appetite disturbances (e.g., difficulty falling asleep or excessive sleeping and/or poor or excessive appetite)? Please describe: ______________

____

____

Please describe any significant circumstances around the birth of your child (complications during pregnancy/delivery, premature): ______________________________

____

____

Who is your child's Primary Care Provider? ______________________________

List of Child's Current Medications

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Has your child ever been admitted to a psychiatric hospital? ❑ Yes ❑ No

Approximate date and reason: ______________________________

____

Has your child ever received a psychological evaluation? ❑ Yes ❑ No

Approximate date and Reason: ______________________________

____

Has your child ever been in therapy? ______________ Length of Therapy: ______________

Reason for therapy: ______________________________

Reason for termination of therapy: ______________________________

Has your child ever made statements about hurting him/herself, or attempted to hurt him/herself?
❑ Yes ❑ No

If yes, please describe: ____

____

____

Family Information

Please describe recent significant family events or stressors (recent move, divorce, marriage, job loss, school change, death): ____

____

Please describe family mental health/psychiatric history (depression, anxiety, addiction, etc.):

____

____

Is there a history of sexual abuse/physical abuse or neglect in the family? ❑ Yes ❑ No
If yes, please explain: ____

____

Has your child ever witnessed domestic violence? ❑ Yes ❑ No
If yes, please explain: ____

____

What methods of discipline do you use with your child? ____

____

____

What do you believe are your child's greatest strengths? ____

____

____

Any additional information that you would like to include: ____

____

____

How did you hear about this psychology practice? ____

General Conduct Form

Please check if your child currently has any of these behaviors:

❑ Easily Distracted	❑ Sadness	❑ Picks at body/skin
❑ Difficulty paying attention	❑ Significant weight loss or gain	❑ Poor memory
❑ Appears Impulsive	❑ Irritability	❑ Doesn't talk much
❑ Frequent crying	❑ Depressed or sad mood	❑ Unusual rituals
❑ Bullies others	❑ Hyperactive	❑ Refuses to go to school
❑ Gets into physical fights	❑ Elevated mood	❑ Jittery, startles easily
❑ Cruel to animals	❑ Low self-esteem	❑ Clinging behavior
❑ Plays with fire	❑ Argues with parents	❑ Other
❑ Use of drugs/alcohol	❑ Unusual fears	
❑ Frequent Lying	❑ Overtired	
❑ Steals	❑ Excessive worries	
❑ Temper outbursts	❑ Avoids places or people	
❑ Skips classes	❑ Repetitive behaviors	
❑ Poor concentration	❑ Sees things that are not present	
❑ Wets clothes or bed	❑ Hears things that are not there	
❑ Soils clothes or bed	❑ Preoccupied with weight	
❑ Fears about parents	❑ Not eating	
❑ Nightmares	❑ Excessive eating	
❑ Bedtime problems	❑ Appears disconnected from others	
❑ Disobeys household rules	❑ Inappropriate touching of other children/adults	

Thank you for providing this information. It will be used to help develop an appropriate treatment plan for your child.

Child's Name: ______________________________