

## Tracey Galgoci Counseling, PLLC Child Intake Form

To be completed by a parent (Please print and fill out as completely as possible)

Date: \_\_\_\_\_ Person completing form: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Mom's cell#: \_\_\_\_\_ Dad's cell #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Education, Occupation, Employer: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Father's Education, Occupation, Employer: \_\_\_\_\_

Are parents:  married  divorced  separated  remarried

Name of Step-mom: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Step-dad: \_\_\_\_\_ Occupation: \_\_\_\_\_

If divorced, Please describe the current custody/visitation arrangement for child: \_\_\_\_\_

Do you have consent from the other custodial parent for treatment of said child? \_\_\_\_\_

Please list all those living in child's home:

Name	Relationship	Age/Occupation

Name of Child's School: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_ Phone #: \_\_\_\_\_

List any learning disabilities: \_\_\_\_\_ Does child have an IEP? \_\_\_\_\_

Have teachers reported any academic concerns? Please explain.

Spiritual Information:

Is spirituality an area of support or strength for your child? \_\_\_ Yes \_\_\_ No

Religious Affiliation: \_\_\_\_\_ Name of Church: \_\_\_\_\_

### **CHILD'S DEVELOPMENTAL/MEDICAL HISTORY**

Did mom drink, smoke or use drugs during pregnancy? Explain: \_\_\_\_\_

Was child born full-term: \_\_\_\_\_ If not, in what week of pregnancy was child born: \_\_\_\_\_

Was baby in a NICU? Explain \_\_\_\_\_

Were child's developmental milestones met on time (walking, talking, toilet training, etc)?

Previous hospitalizations: Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

List any medical conditions or disabilities: \_\_\_\_\_

Current medications and dosage: \_\_\_\_\_

Is your child's nutrition generally good? Any concerns in this area? \_\_\_\_\_

Does your child have good sleeping habits? Any concerns in this area? \_\_\_\_\_

Who disciplines the child and what forms of discipline are used? \_\_\_\_\_

### **COUNSELING/PSYCHIATRIC HISTORY**

Has your child had any previous counseling? \_\_\_\_\_ If yes, when? \_\_\_\_\_

For what reason? \_\_\_\_\_

Name of previous counselor: \_\_\_\_\_

Please describe any concerns about your family listed below:

Health Concerns: \_\_\_\_\_

Mental Illness: \_\_\_\_\_

Alcoholism/drug addiction: \_\_\_\_\_

Death in Family: \_\_\_\_\_

Job loss: \_\_\_\_\_

Marital difficulties: \_\_\_\_\_

Physical/sexual/emotional abuse: \_\_\_\_\_

### **REASONS FOR SEEKING HELP**

What concerns about your child have brought you to counseling today? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did the present concern begin to be a problem? \_\_\_\_\_

Where are these concerns presenting the most problems for YOU? Please check all that apply.

Home  Work  Marriage  Other

Where are these concerns causing the most problems for the CHILD? Check all that apply.

Home  School  Friends  Other

What have you done so far to deal with this problem?

Describe your child's relationship with:

Mom: \_\_\_\_\_

Dad: \_\_\_\_\_

Siblings: \_\_\_\_\_

Teacher: \_\_\_\_\_

Friends: \_\_\_\_\_

What are your child's strengths and interests?

What do you hope to gain from counseling?