

Franci Smith, M.S., MFT
Licensed Marriage and Family Therapist
(925) 588-3070

Child Intake Form

Date of Intake: _____

Child's Name: _____ Date of Birth.: _____

Address: _____ Phone: _____

Age: _____ School: _____ Phone: _____

Teacher: _____ Grade: _____

Name of Parents: _____

Best way to reach you: _____
(phone, email, etc.)

1. REASON FOR REFERRAL:

Who referred you? _____

What do you perceive the problem to be? _____

2. BACKGROUND INFORMATION

A. General background history

Name of Mother: _____

Education: _____

Profession: _____

Name of Father: _____

Education: _____

Profession: _____

List family members (siblings, other(s) living with child):

Relationship to child	Age	Gender	Lives at home?

B. Other pertinent background history

Parents' marital status? _____

If parents are not married, then:

Do you have a significant other? _____

Does s/he live with the family? _____

How do(es) the child(ren) get along with him/her? _____

If parent divorced or widowed:

When (how old was the child)? _____

Who has custody of the child? _____

Relationship with non-custodial parent: (How often does your child see him/her?) _____

C. DEVELOPMENTAL HISTORY

Pregnancy with child: _____

Delivery and perinatal complications, if any?: _____

How was your child as a baby? _____

Developmental Milestones: (comment on any problems)

1. Motor_____

2. Language:_____

D. MEDICAL HISTORY:

1. Hospitalizations?_____

2. Chronic Illnesses (e.g. asthma, diabetes, allergies, etc.)?_____

3. Allergies?_____

4. Other illnesses?_____

5. Accidents. If so, when and what happened?_____

Loss of consciousness?_____ For how long?_____

Medication History (past and present):_____

E. SCHOOL INFORMATION

How does your child do in school academically? _____

What are your child's grades?_____

Special placement in school?_____

Has your child been evaluated in the past?_____

Reason for evaluation:_____

How does your child do in school behaviorally?_____

Does your child have a learning or physical disability? __Y, __N, __Maybe.

Please specify: _____

Does your child have a mental health diagnosis? __Y, __N

Please specify: _____

F. SOCIAL LIFE

1. Does your child have many friends? _____

2. Does your child have problems socially? Please describe: _____

3. What kind of activities does your child do with her/his friends? _____

4. How does s/he get along with other children at school? _____

5. What does your child do for fun? (activities, hobbies, sports, etc.) _____

G. OTHER RELEVANT INFORMATION

Additional information that could help me understand your child better:

Briefly describe your goals for your child's therapy:

Thank you for taking the time to fill out this form.

Franci Smith, MFT