Full Circle Therapy Center, PLLC
Nicole Siegel, LCSW, LCDC

Child Intake Form and Identifiable Information

Child's Name:_____ Date:_____

Child's Address: _____ Apt_____

City: _____ State:_____ Zip Code: _____

Child's race:_____ Date of Birth_____/_____/_____ Age:_____Gender:_____M_____F

Father's Name:_____Date of Birth_____/_____/_____ Age:_____

Father's Employer:_____Occupation:_____

Mother's Name:_____Date of Birth_____/_____/_____ Age:_____

Mother's Employer:_____Occupation:_____

Legal Guardian's Name/relationship (if different from mother & father):_____

E-mail:_____Ok to contact _____Yes _____ No

Home Phone:_____Ok to contact _____Yes _____ No

Cell Phone: _____Ok to contact _____Yes _____ No

Does child live with both biological parents? ___Yes ___No If no, are parents married, separated, divorced, or widowed, how long:_____

Are parents remarried? If so, list partner's names:_____

Child's School:_____ Grade:_____

Child's Social Security Number:_____-_____-_____

Was child referred to counseling? ___Yes ___No If Yes, by whom?_____

Names and ages of others living in your home:

Name:	Relationship:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

_____ _____ _____

___Yes ___No Has child ever been treated by a physician?

___Yes ___No Has child ever been treated by a counselor/therapist?

If yes, who did you see? _____

Child's Physician: _____

Last time see by physician: _____

Reason for visit: _____

Is child on medication? ___Yes ___No If yes, what medication(s) _____

_____

___Yes ___No Has child been diagnosed with developmental problems?

___Yes ___No Any speech impairment problems?

___Yes ___No Has child been exposed to trauma?

___Yes ___No Any mental health problems on fathers/mothers family? If yes, please indicate who and what diagnosis? _____

___Yes ___No Any complications during pregnancy?

___Yes ___No Any complications at birth?

Briefly describe your reasons for seeking counseling services:_____

_____

What kind of things have you tried so far to handle this situation?: _____

_____

How did you hear about us? (circle option) Friend/Family Our Website Psychology Today Other_____

Please place a number that best corresponds to the issue listed below: (rate those that apply)

NEVER RARELY SOMETIMES OFTEN ALWAYS
1 2 3 4 5 6 7 8 9 10

___ Abuse- physical

___ Abuse- neglect

___ Anger, hostility, irritable

___ Compulsions

___ Depression

___ Drug Use

___ Guilt

___ Judgment

___ Obsession/compulsion

___ PTSD

___Suicidal thoughts

___Thought disorganization

___Abuse-sexual

___Aggression, violence

___Anxiety, nervousness

___Cruelty to animals

___Decision-making, indecision

___Divorce, separation

___Eating problems

___Grieving

___Headaches

___Loss of control

___Panic/anxiety attacks

___School problems

___Sleep problems

___Tobacco use

___Abuse-emotional

___Alcohol use

___Attention, distraction

___Confusion

___Crying, sadness

___Delusions (false ideas)

___Impulsiveness

___Mood swings

___Self-esteem

___Stress

___Temper/low tolerance

Other:_____

In the past 36 months has there been a death of a family member? Or someone close to the child?

___Yes ___No If yes, who?:_____ When:_____

Prior to the 36 months, has there been a death of someone that was close to the child?

___Yes ___No If yes, who?:_____ When:_____

Please rate below on a scale of 1 through 10, 1=not at all, and a 10=very much so:

___Child is very close and had a good relationship with siblings.

___Child has several close friends.

___Child often has nightmares.

___Child prefers to spend time alone.

___Child likes self.

___Child is confused with identity.

___ Child does not make eye contact when spoken to.

___ Child does not like being around other people.