Nancy Missildine, Licensed MFT 42041
Le Tisdale, Licensed MFT 19817

Child/Teen Intake Form

Date_____ Informant_____ Referred by_____

Child's Name_____
Last First Middle Nickname

Date of Birth_____ Age_____ Sex_____ Grade_____

Mother's Name_____ Date of Birth_____

Address_____
Street City State Zip

Phone Home _____ Cell _____ Work_____

Father's Name_____ Date of Birth_____

Address_____
Street City State Zip

Phone Home _____ Cell _____ Work_____

Religious Preference (Optional)_____

Primary Insurance Carrier_____ Insured_____

Date of Birth_____ Employee ID#_____ Group #_____

Employer_____ Effective Dates of Coverage_____ Phone # _____

Billing Address_____ City _____ State_____ Zip_____

In the event of an emergency and I must cancel, where should I call_____

Non-Family Emergency Contact_____
Name Home Phone Cell Work

What concerns do you have about your child?_____

_____

How long have these existed?_____

What do you think might be causing this?_____

Anyone else expressed concerns about your child?_____

What are your expectations for therapy? _____

_____

Has your child ever been seen by another counselor? Yes_____ No_____ Dates_____

Who?_____ Outcome_____

Who will participate in child's therapy? Mom: Yes_____ No_____ Dad: Yes_____ No_____

Step Mom: Yes_____ No_____ Step Dad: Yes_____ No_____

Others: _____

1777 Hamilton Avenue, Suite 2040, • San Jose, CA. 95125
Phone 408-266-5800 Fax 408-266-5809
www.transitions-therapy.com

Nancy Missildine, Licensed MFT 42041
Le Tisdale, Licensed MFT 19817

Family Information

Name	Age	Education	Occupation	Does child get along with them?
Mother_____	_____	_____	_____	_____
Father_____	_____	_____	_____	_____
Step Parent_____	_____	_____	_____	_____
Sister_____	_____	_____	_____	_____
Brother_____	_____	_____	_____	_____
Step Siblings_____	_____	_____	_____	_____
Half Siblings_____	_____	_____	_____	_____

List persons living in the home with child_____

Is child adopted? Yes_____ No_____ When?_____ Divorce? Yes_____ No_____ When?_____

If divorced, describe your relationship with the child's other biological parent_____

Dates of remarriage: Mom_____ Dad_____ Describe child's relationship with step mom/dad_____

Any serious marital strife leading to separation? Yes_____ No_____ Dates_____

Parents significant unhappiness or worry during child's first three years?_____

Any history of mental illness in family, diagnosed or undiagnosed in child's blood relatives (parents, grandparents, siblings, aunts, uncles, etc)

_____

Current marital satisfaction of Mom _____ Dad_____ Length of marriage to child's biological parent_____

Biggest struggle in your family's history_____

Current stressors in family_____

Child's reaction to birth of sisters and brothers_____

Parental unemployment? Dates:_____

Any deaths your child has experienced? (family, friend, pet)_____

Any moves? If so, when and where_____

Child exposed to disaster? Describe_____

Any lengthy separation from either parent?_____

Describe your child's contact with other children (church, sporting events, etc.)_____

_____How often?_____

What are your child's favorite activities?_____

1777 Hamilton Avenue, Suite 2040, • San Jose, CA. 95125
Phone 408-266-5800 Fax 408-266-5809
www.transitions-therapy.com

Nancy Missildine, Licensed MFT 42041
Le Tisdale, Licensed MFT 19817

What does your child dislike doing the most?_____

Describe your child's temperament_____

Who is your child like?_____

What are your child's strengths?_____

What makes your child mad?_____

What are your child's responsibilities?_____

Developmental History

Parental attitude of pregnancy_____

Was mother on medication or drugs during pregnancy? If yes, please explain_____

Mother's health after delivery_____

Primary caretaker for first year_____

Did Mother and child attach/bond?_____ Did Father and child attach/bond?_____

Birth weight_____ Age walked_____ Age talked_____ Age potty trained_____

Please rate your child's development in the following areas:

	Below Average	Average	Above Average
Social	_____	_____	_____
Emotional	_____	_____	_____
Intellectua	_____	_____	_____
Physical	_____	_____	_____
Language	_____	_____	_____
Behavioral	_____	_____	_____

Age began nursery school/day care _____ Any separation problems?_____

Any speech/language isues?_____

Any problems with bed-wetting? _____

Any problems with bladder/ bowel control? _____

Any eating problems? _____

Any sleep problems? _____ Hours per night?_____

Any fears? _____

Any gender identity issues?_____

1777 Hamilton Avenue, Suite 2040, • San Jose, CA. 95125
Phone 408-266-5800 Fax 408-266-5809
www.transitions-therapy.com

Nancy Missildine, Licensed MFT 42041
Le Tisdale, Licensed MFT 19817

Sensitivity to sounds, noises, textures?_____

Does your child engage in rituals or exhibit any compulsive behaviors?_____

Any physical, sexual, emotional or verbal abuse?_____

Parenting

Discipline style: Mom:_____

Dad:_____

How does each parent spend alone time with the child doing something they both enjoy?

Mom _____ How often?_____

Dad_____ How often?_____

Is spending time alone with your child pleasurable or frustrating?_____

Are you confident in your parenting abilities?_____

What desires do you have for your child?_____

What does your family do together?_____

Do parents support each other in parenting?_____

Medical History

Child's Pediatrician_____ Is child currently being treated for any medical problem?_____

If yes, please explain_____

Is child currently taking any medications? If so, list_____

Explain any problems during pregnancy or soon after, including mother's illness_____

_____

Were there problems with delivery?_____

Was child carried full term? If no, explain_____

Any hospitalizations or surgeries?_____

Any head trauma**?**_____ Any physical handicaps or deformities?_____

Any seizures or convulsions**?**_____ Any allergies or drug tolerances**?**_____

Describe any serious health problems or injuries in family_____

School History

Child's School_____ Teacher_____

Special Class? Yes_____ No_____ Describe_____

Current School Performance: Academic

1777 Hamilton Avenue, Suite 2040, • San Jose, CA. 95125
Phone 408-266-5800 Fax 408-266-5809
www.transitions-therapy.com

Nancy Missildine, Licensed MFT 42041
Le Tisdale, Licensed MFT 19817

Above average_____ Average_____ Below Average_____ Failing_____

Current School Performance: Behavior

Above average_____ Average_____ Below Average_____ Failing_____

Please describe any academic or behavioral problems your child is experiencing in school_____

_____

When did these begin?_____ Repeated a grade? Yes_____No_____ Which one?

What do teachers say about your child?_____

Has your child changed schools for any reason?_____

What does your child like best about school?_____

What does your child like least about school?_____

Is your child currently in any after school or daycare program?_____

Any additional comments_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

1777 Hamilton Avenue, Suite 2040, • San Jose, CA. 95125
Phone 408-266-5800 Fax 408-266-5809
www.transitions-therapy.com