

# WEST MICHIGAN PSYCHOLOGICAL SERVICES

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## CHILD INTAKE ASSESSMENT

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Biological Sex: \_\_\_\_\_ Preferred Gender Pronoun: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Questionnaire filled out by:                  Father                  Mother                  Both                  Other: \_\_\_\_\_

### Presenting Problems:

What are your concerns regarding your child at this time?

In addition to the concerns expressed above, please check each symptom below that applies to your child and rate each symptom checked with a measurement of severity. (Scale of 1 to 10: 1=minimally problematic, 10=extremely problematic)

#### Rating

\_\_\_\_\_ Disturbing thoughts (Specify types of thoughts: \_\_\_\_\_)

\_\_\_\_\_ Self-Harming behavior (Explain: \_\_\_\_\_)

\_\_\_\_\_ Suicidal thoughts

\_\_\_\_\_ Homicidal thoughts

\_\_\_\_\_ Fears/fearfulness (Specify types of fears: \_\_\_\_\_)

\_\_\_\_\_ Sleep difficulties:                  Falling asleep                  Waking up                  Low Energy

\_\_\_\_\_ Stress (Specify: \_\_\_\_\_)

\_\_\_\_\_ Gender Identity Issues

\_\_\_\_\_ School/Work problems (Specify either or both: \_\_\_\_\_)

\_\_\_\_\_ Family problems (Specify type and individuals involved: \_\_\_\_\_)

\_\_\_\_\_ Anger problems, oppositional and/or defiant behaviors (Specify home, school, or both: \_\_\_\_\_)

\_\_\_\_\_ Violence (Specify type and toward whom: \_\_\_\_\_)

\_\_\_\_\_ Legal problems (Specify type: \_\_\_\_\_)

\_\_\_\_\_ Other (Specify: \_\_\_\_\_)

## Developmental History for Children & Adolescents:

Pregnancy: Normal Illnesses Meds Bleeding Other: \_\_\_\_\_

Birth: Full term Premature C-Section Complications

Ages of: Supporting head: \_\_\_\_\_ Rolling over: \_\_\_\_\_ Sitting: \_\_\_\_\_ Crawling: \_\_\_\_\_

Walking: \_\_\_\_\_ First word: \_\_\_\_\_ Feeding self: \_\_\_\_\_ Toilet training: \_\_\_\_\_

Trauma: Separation Divorce Death Surgeries Illnesses

Adjustment Problems: Crying Stuttering Thumb sucking Nail biting

Bedwetting Nightmares Excessive fears Tantrums

Cruelty Jealousy Hyperactive Stealing Lying

Shy Dependent Low self-confidence Mood swings

Other: \_\_\_\_\_

### Social Development:

How many friends does our child have? \_\_\_\_\_

How would you describe your child? \_\_\_\_\_

Passive / Assertive

Dependent / Independent

Calm / Anxious

Happy / Sad-Depressed

Trusting / Suspicious

Sensitive / Calloused

Conforming / Rebellious

Thoughtful / Impulsive

Inferiority / Self-assured

Serious / Carefree

Conventional / Risk-taking

Shy / Outgoing

Demanding / Adaptable

Selfish / Considerate

Detached / Warm

### Mental Health History:

Has your child received counseling in the past? Yes No

If yes, when, with whom, and for what reason?

Has your child been hospitalized for a mental health issue? Yes No

If yes, when and for what reason?

Is there a family history of mental health problems or nervous problems?

Yes

No

If yes, please explain.

**Substance Use/Abuse History:**

	<u>None</u>	<u>Past</u>	<u>Present</u>	<u>Frequency/Amount</u>
Alcohol				_____
Drugs				_____
Nicotine				_____
Caffeine				_____

Has your child received treatment for any of the above substances?

Yes

No

If yes, when, for what substance, and for how long?

Are there any family members with substance abuse problems?

Yes

No

If yes, list relationship and substance abused:

**Medical History:**

Who is your child's current Primary Care Physician: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Describe any present or past health concerns/problems, including any traumas or surgeries.

List all medications and dosages your child is currently taking:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent weight gain or loss: \_\_\_\_\_ lbs.

Appetite: \_\_\_\_\_

**Family History:**

Parent's marital status:            Married            Separated            Divorced (# of times: \_\_\_\_\_)

If married, how would you describe the quality/satisfaction of your marriage?

If divorced, describe the custody arrangements:

Describe your relationship as parents (and step-parents, if applicable) with your child:

Father:

Mother:

Step-parent:

<u>Sibling's Names:</u>		<u>Age</u>	<u>Marital Status</u>	<u>Occupation</u>
_____	M   F	_____	M   S   D	_____
_____	M   F	_____	M   S   D	_____
_____	M   F	_____	M   S   D	_____
_____	M   F	_____	M   S   D	_____
_____	M   F	_____	M   S   D	_____

Describe your child's relationship with his/her siblings:

How would you describe your relationship with your children?

**Educational/Employment History:**

Child's current grade: \_\_\_\_\_ School: \_\_\_\_\_

Describe any learning disabilities/difficulties for your child:

Describe any behavioral/discipline problems:

Describe your child's relationship with peers:

If employed, what job does your child hold and for how long?

**Legal History:**

Number of arrests: \_\_\_\_\_ Number of substance-related arrests: \_\_\_\_\_

Number of OUIL, DUIL, or DWO arrests: \_\_\_\_\_

Nature of other arrests:

Other legal concerns:

**Religious/Spiritual Background:**

List any formal religious affiliation:

Please describe your child's involvement:

**Cultural/Racial Identity:**

White/Caucasian

African American

Asian

Hispanic

American Indian

Middle Eastern

Muslim

Hindu/Buddhist