Intake Form

Healing Center at Silver Lake Gardens

Name		
Billing address		
City	STATE	ZIP CODE
Telephone (home)	Telephone (CELL)	
E-Mail	Other:	

Parents Marital Status

Single, never married		Mothers Current Age:		Was adopted	
Married		Mother's Current Occupation:		If so, is child aware?	
Separated; When:		Father's Current Age:		Is a foster child	
Divorced; When:		Father's Current Occupation:		If so, since when	
Widowed; When:		Guardian's Current Age		Sister(s) and Ages	
Remarried; When:		Guardian's Current Occupation		Brother(s) and Ages	

Please Check All That Apply To Your Child:

Can't concentrate / pay attention	Inappropriate sexual activity	Confused thinking or beliefs
Restless or hyperactive	School suspensions / alternative school	Feels people are "out to get" him or her
Talks too much / talks out of turn	Frequent sadness or irritability	Unable to care for hygiene, nutrition or basic needs
Impulsive or acts without thinking	Tearful / Cries easily	Odd or bizarre thoughts or behavior
Trouble staying seated	Low energy level	Behaves like a younger child
Makes careless mistakes	Suicidal thoughts, threats, or actions	Has trouble communicating
Fails to finish things he/she starts	Low self-esteem or guilt	Avoids or seems obsessed with certain things
Feeling irritable	Dislike of his/her body	Sensory experiences / issues
Daydreams / Gets lost in thought	Cuts, burns or intentionally causes harm to self	Makes repetitive sounds or body movements
Inattentive / Easily Distracted	Loss of interest in favorite activities	Fascinated with odd objects or parts of toys
Has trouble following directions	Has trouble making and keeping friends	Uses people as objects
Forgetful / Often loses things	Feelings hurt easily	Lack of imaginary or pretend play
Angry / Resentful	Severe changes in mood	Does not seek to share interests
Does not mind / Argues	Talks too much, fast, changes topic quickly	Does not make friends / in his or her own world
Annoys others purposely	Thoughts racing	Does not keep eye contact
Bullies / Threatens / Intimidates others	Increased goal-directed activities	Rituals or routines that must be followed
Physical Aggression	Unrealistic highs in self-esteem	Problems with wetting or soiling self
Homicidal / Threats to kill others	Worries about safety of self or others	Problems falling asleep
Destroys property	Unusual worries or fears	Problems staying asleep / Nightmares
Temper Tantrums / Loses temper easily	Panic attacks	Picky eater
Lies / Blames others for own misbehavior	Panics / tantrums when separated from parent	Trouble with academics / behavior
Cruel to animals	Obsessive thoughts	Is not affectionate
Has set fires	Unusual behaviors with dressing, bathing, mealtime or counting rituals	Difficulty controlling emotions
Violates curfew / Has run away	Nervous tics or other repetitive, abrupt nervous movements or vocal noises	Other:
Suspected smoking / alcohol / drug abuse	Sees or hears things that are not real	

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DEVELOPMENTAL HISTORY:

BORN: How Many Weeks:	On – Time	Weeks Late	
Baby weighed:	How long was the baby in the hospital:	No complications	
Biological Mother's age at child's birth		Caesarean section	
If child was adopted, child's age at adoption		Multiple births	
If not biological child of parent, is the child aware of this?		Cord around neck	
Any problems experienced by the mother during pregnancy:		Forceps/ vacuum assisted	
What was your child's personality from age 0 to 1 year:		Other:	
Easy going			
Slow to warm up to others			
Demanding and difficult to please	Other:		

At What Age Did Your Child Do The Following?

Sat up without support		Spoke first word		Dressed him/herself	
Crawled		Say 2 or more words together		Drew a circle	
Walked alone		Became toilet trained (day)		Any other information you would like to offer us:	
Gave up bottle / breast		Became toilet trained (night)			

Please Check Any Of The Following That Applied During The First Month After Birth:

Stay in intensive care nursery		Surgery		What kind of surgery?	
Breathing problems		Physical deformities		Medications given:	
Jaundice		Excessive crying			
Cyanosis		Sleeping Problem			
Convulsions/seizures		Very inactive			
Feeding problems		Very jittery			
Injury		Other:			

Child's Medical History

Asthma		Eye & / or Vision Problems		Genetic or Chromosomal Testing	
Recurrent Ear Infections / Tubes		Bowel Problems		EEG, MRI, or CT	
Meningitis & / or Encephalitis		Slow Weight Gain		Serious Injury:	
Headaches & / or Migraines		German Measles, Whooping Cough, Measles, Mumps, or Chick Pox, Scarlet Fever		Hospitalization:	
Seizures		Diabetes (Type 1, Type II)		Surgery:	
Head Injuries & / or Concussions		Lead Exposure		Other:	

What Medication(s) has your child taken or is now taking?

	MEDICATION	DATES	REASON	EFFECTIVENESS
1.				
2.				
3.				
4.				
5.				
6.				

Prior Counseling / Treatment Information

Please fill in the following information, regarding past mental health services:

Therapy / Hospitalizations / Psychiatric Services / Psychologist / Testing	Dates	Ages

Educational History

What school does your child attend?	
Current Grade?	
Has your child ever repeated a grade, been retained, or held back?	
If so, what grade?	

Check your child's current academic performance:	**Please check any of the following services that your child has ever received or has any difficulties with.**	
Above Grade Level	Special Education / Resource Services	IEP
At Grade Level	Occupational Therapy	504 Plan
Below Grade Level	Self – contained classroom at school	Spelling difficulties
Inconsistent	Team taught Classes	Reading difficulties
Receives after school help	Physical Therapy	Math difficulties
Has a tutor	Speech / Language Therapy	All Subject difficulties
Needs additional help but has no services	Social Worker Services at school	Peer Relationship Issues

Activity

Approximately how many hours per day does your child watch TV or play video games?	
Approximately how many hours per day does your child spend completing homework?	
Approximately what time does your child go to bed at night?	Wake up?

Describe special areas of interests or hobbies (e.g. sports, art, reading, church activities, scouts, etc.)

Activity	How much time per week?	How long participated?

Please check any of the following events that have happened for anyone in the family in the past 6 months.	**If any of the child's relatives have had any of the following conditions, please check the condition and write the person's relationship next to it. Ex. Parents, brothers, sisters, grandparents, aunts, uncles, cousins.**	
Increase marital conflict	Convulsions, seizures, epilepsy	Alcohol Abuse
Separation or divorce	Speech problems	Substance Abuse / Addiction
Remarriage	Slow development	Thyroid disease
Death in family	Learning problems in reading , writing, math	Intellectual Disability
Loss of job	Autism / PDD / Aspergers	ADD or ADHD
Change in living situation	Depression	Anxiety
Trauma or injury	Bipolar / Manic Depression	Suicide Attempts
Serious Illness / Hospitalization	Other	
New Baby		
Legal Trouble	**Thank you. Please return this questionnaire to your provider.**	
Other		

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