



Behavioral

Health Services of Atlanta

Child Intake Form

Please provide the following information about your child:

Full Name: _____

Nick Name: _____

Birth Date: _____ Today's Date: _____

Observed Behaviors:

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:

What does your child do that you like? What does he/she do that other people like?

Others Concerns:

Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals: _____

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Client Name _____

Has your child previously received behavioral health services? Yes No

If yes, please list providers:

Psychiatrist _____

Counselor _____

Group Counseling _____

Where you satisfied with services? Yes No If No, Please describe

Family History

The name of the child's biological parents:

Mother: _____ Father: _____

Who has legal guardianship of your child? _____

Who are other household members with your child?

Names	Ages	Relationship to child

Who are your child's significant others NOT living with your child?

Names	Ages	Relationship to child

Client Name _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc

Condition	Please circle	Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : Please Describe	

Education History

What school does your child attend?

Address: _____

Phone: _____ Teacher's Name: _____

Current Grade: _____

What does your child's teacher say about him/her?

Other schools attended (including pre-school):

Name of School	Dates/Grade Attended

Client Name _____

Has your child ever repeated a grade? If so which one(s)?

Has your child ever received special education services?

Has your child experienced any of the following problems at School? Please circle all that apply

Fighting	Lack of friends	Drug/Alcohol	Detention
Suspension	Learning Disabilities	Poor attendance	Poor grades
Gang influence	Incomplete homework	Behavior problems	

Medical History

What is the name of your child's primary care physician? _____

Address: _____ Phone: _____

Date of your child's last medical examination: _____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems? Please circle all that apply

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness	Other	

Client Name _____

Please list any current medical problems or physical or developmental diagnosis/concern:

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Began/Stopped

Other History

Has your child ever experienced any type of abuse (physical, sexual, or verbal)? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?