CHILD INTAKE

Children under 14

Child's Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ Gender _____

Describe the reason you are bringing your child for counseling

_____

Who referred you to JFS/Mynd Works?

_____

Preferred method of contact (choose one and provide contact information):

☐ Email ☐ Text ☐ Phone

Email Address: _____ Phone Number: _____

Family Information

Parent/Guardian _____ Birthdate _____ Relation _____

Primary Phone _____

Address (if different) _____

City _____ State _____ Zip _____

Parent/Guardian _____ Birthdate _____ Relation _____

Primary Phone _____

Address (if different) _____

City _____ State _____ Zip _____

Insurance Company _____

Is there a secondary insurance?
☐ YES ☐ NO

Member ID _____

Phone # from back of card _____

Policy Holder _____ Policy holder date of birth _____

Please list ALL persons living with the child (including parents/guardians):

Name	Relationship to Child	Date of Birth	Gender	Marital Status	Employer/Occupation

Please list family members NOT living with the child (Parent, Siblings, Stepparents, Birth Parents, etc.):

Name	Relationship to Child	Date of Birth	Gender	Marital Status	Employer/Occupation

Family's religious, spiritual, cultural, or sexual identity information you wish to share

Is the child now or has the child been in any of the following?

☐ Foster Care ☐ Custody of Relative ☐ Adopted

If yes, please briefly describe the situation

Social

How does the child get along with peers/friends?

How does the child get along with parents/caregivers or other adults?

How does the child get along with sibling(s)?

Does the child have hobbies or participate in activities (sports, school clubs, scouts, etc.)?

Educational

Current Grade

School/School District

What other schools has the child attended?

Does the child have an Individualized Education Plan (IEP)? ☐ YES ☐ NO

If yes, what type?

- ☐ Autism
- ☐ Deaf/Blindness
- ☐ Deafness
- ☐ Emotional disturbance
- ☐ Hearing impairment
- ☐ Intellectual disability
- ☐ Multiple disabilities
- ☐ Orthopedic impairment
- ☐ Other health impairment
- ☐ Specific learning disability
- ☐ Speech or language impairment
- ☐ Traumatic brain injury
- ☐ Visual impairment

Does the child have academic, attendance, or behavioral issues? ☐ YES ☐ NO

If yes, please describe:

Developmental History

Was the baby carried to term? ☐ YES ☐ NO

Birth Weight:

Did mother or child experience medical complications during pregnancy, delivery, or following delivery?
☐ YES ☐ NO

If yes, please briefly describe

Did the child meet developmental milestones (walking, talking, toilet-training, school readiness skills, etc.) at expected ages? ☐ YES ☐ NO

If no, please briefly describe

Physical and Mental Health History

Has the child been prescribed any medication(s)? ☐ YES ☐ NO

If yes, please provide the following:

Name	Dosage	Frequency	Reason For Taking	Who prescribed it?

Does the child have any allergies? ☐ YES ☐ NO

If yes, please describe:

Please check all that apply to the child, and describe briefly if checked:

- ☐ current medical conditions
- ☐ medical problems in the past
- ☐ sleep problems
- ☐ problems with eating habits
- ☐ problems with personal hygiene
- ☐ other health concerns

Does the child have any previous mental health diagnosis? ☐ YES ☐ NO
If yes, please list:

If yes, who gave the diagnosis and when?

Has the child ever been involved with any of the following services?

Previous	Current		Approx. Date/Name of Provider/Agency
☐	☐	Outpatient Counseling/Therapy	
☐	☐	Psychological evaluation	
☐	☐	Psychiatric evaluation	
☐	☐	Psychiatric Med. Management	
☐	☐	BHRS Services (BSC, MT, TSS)	
☐	☐	Family-Based Mental Health	
☐	☐	Speech/Language Therapy	
☐	☐	Occupational Therapy	
☐	☐	Children & Youth/CPS	
☐	☐	Other (describe):	

.Has the child experienced any of the following (if yes, please briefly describe the situation)?

- ☐ abuse-physical, emotional, or sexual
- ☐ witnessing domestic violence
- ☐ prolonged separations from parents or caregivers)
- ☐ other trauma

Please indicate if any person in the child's birth or adoptive family has experienced the following:

	Name/Relationship to the child:
☐ ADHD	
☐ Anxiety Disorder	
☐ Bipolar Disorder	
☐ Chronic Physical Illness	
☐ Depression	
☐ Drug and/or Alcohol Abuse	
☐ Learning Problems	
☐ Other Physical or Mental Illness	
☐ Schizophrenia	

Please describe the child's overall strengths and areas of concern:

☐ *By checking this box AND typing my name, I am verifying that this is my electronic signature*

Signature of Person Completing Form | Relationship to Child | Date