New Perspectives Counselling
Caroline Krupica and Associates

CHILD / ADOLESCENT INTAKE FORM

Today's date: _____

Child's Full Name: _____

Date of Birth: _____ Age: _____

Name of School: _____ Grade: _____

Ethnicity: _____ Religious Affiliation: _____

Person(s) completing this form:

_____

Who suggested that you contact NPC?:

_____

Child's custodian/guardian(s) is/are:

_____

Child's home address:

_____

City: _____ Prov: _____ Postal Code: _____

Home Telephone: _____ Other Phone (specify): _____

Email Address:_____

OK to contact you/child at home? ❑ Yes ❑ No OK to leave a message? ❑ Yes ❑ No

Special Instructions? _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____Relationship to Child: _____

Address:_____ City: _____Prov: _____ Postal Code: _____

Home Telephone: _____Other Phone
(specify)_____

Email:_____

MOTHER'S INFORMATION

Mother's Name: _____ Date of Birth: _____
Home Telephone: _____ Other Telephone(Specify) _____

Address: _____

City: _____ Prov:_____ Postal Code: _____

Ethnicity: _____ Religious Affiliation: _____

Highest Grade/Education: _____

Marital/relationship status (Check one):

❑ Married ❑ Live with Partner ❑ Single ❑ Separated/Divorced ❑ Widowed

❑ Other: _____

Employment Status (Check all that apply):

❑ Employed ❑ Retired ❑ Disabled ❑ Student ❑ Homemaker ❑ Unemployed

If/When employed, what type of work do you do?
_____

Place of Employment:_____

Years in Current Job: _____ Business Phone: _____

OK to contact mother at work? ❑ Yes ❑ No OK to leave a message? ❑ Yes ❑ No

Special calling instructions? _____

FATHER'S INFORMATION

Father's Name: _____ Date of Birth: _____

Home Telephone: _____ Other Telephone (Specify): _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Ethnicity: _____ Religious Affiliation: _____

Highest
Grade/Education: _____

Marital/relationship status (Check one):

❑ Married ❑ Live with Partner ❑ Single ❑ Separated/Divorced ❑ Widowed ❑ Other: _____

Employment Status (Check all that apply):

❑ Employed ❑ Retired ❑ Disabled ❑ Student ❑ Homemaker ❑ Unemployed

If/When employed, what type of work do you do?

_____

Place of Employment_____

Years in Current Job: _____ Business Phone: _____

OK to contact mother at work? ❑ Yes ❑ No OK to leave a message? ❑ Yes ❑ No

Special calling instructions? _____

REASON FOR SEEKING TREATMENT

Please briefly describe the problem(s) your child is experiencing:

_____

What has happened to cause you to seek help NOW?

_____

What do you hope to be able to do or achieve as a result of treatment?

_____

What do you consider to be other stresses in your child's life?

_____

HISTORY OF PROBLEM

When did your child first start experiencing the problem(s) that brought you to NPC today?

_____

How often does the problem occur? _____
How long does it last? _____
Does your child have any thoughts of harming him/herself? ❑ No ❑ Yes
Has your child ever attempted to harm him/herself? ❑ No ❑ Yes
If yes, please explain: _____
Does your child have any thoughts of harming someone else? ❑ Yes ❑ No
Has your child ever attempted to harm someone else? ❑ No ❑ Yes
If yes, please explain: _____
Has your child ever had previous therapy/counselling of any kind? ❑ No ❑ Yes
If yes, when and for how long? _____
What concerns were addressed in therapy?

_____

Was this experience helpful (please explain)?

_____

Has your child ever been hospitalized for emotional/behavioral problems? ❑ No ❑ Yes
If yes, when/where was this?

_____

Has your child been prescribed medications to control emotional/behavioral problems? ❑ No ❑ Yes
If yes, please list medications, when prescribed, and by whom:

_____

To your knowledge, has your child experimented with alcohol/drugs? ❑ No ❑ Yes
Are you concerned that your child might have/is developing a problem with alcohol or drug abuse? ❑ No ❑ Yes
If yes, please explain:

_____

FAMILY HISTORY

Has your child experienced any parental separations, divorces, or deaths? ❑ No ❑ Yes
If yes, when: _____ How old was the child at the time? _____

Please describe the circumstances:

_____

If parents are separated or divorced, who has custody of this child? _____
How often does the other parent see this child?
❑ Weekly or more often ❑ Once or twice a month ❑ Few times a year ❑ Never

Please list the age and sex for each sibling (including those deceased and step siblings

Age	Sex	Relationship to Child	Living at Home?

Other than parents and any children already indicated above, who else lives in the child's household?

_____

Has anyone in the child's family had treatment for emotional/ psychological concerns? ❑ No ❑ Yes
If yes, please briefly explain who/when?_____
Has anyone in the child's family ever attempted or committed suicide? ❑ No ❑ Yes
If yes, please briefly explain who/when?

_____

FAMILY HEALTH

Describe father's present health: _____
Describe mother's present health:_____
Have any family members had any of the following (PLEASE CHECK IF YES)

☐ Cancer	☐ Multiple Sclerosis	☐ Physical Disability
☐ Diabetes	☐ Alzheimer's Disease	☐ Reading Difficulties
☐ Behaviour Disorder	☐ Speech/Language Impediment	☐ Sickle Cell Anemia
☐ Mental Illness	☐ Sleep Difficulties	☐ Anxiety
☐ Seizures/Epilepsy	☐ Cerebral Palsy	☐ Diabetes
☐ Tourette's	☐ Alcohol/Drug Abuse	☐ Heart Disease
☐ Severe Head Injury	☐ High Blood Pressure	☐ Depression
☐ Migraine Headaches	☐ Physical Disability	☐ Stroke
☐ Attention Deficit/ Hyperactivity Disorder	☐ Reading Difficulties	☐ Kidney Disease
	☐ Sickle Cell Anemia	☐ Nervousness
☐ Bipolar Disorder	☐ Anxiety	☐ Tuberculosis
☐ Food Allergies		☐ Tics

Other learning difficulties: _____
Other significant health or emotional difficulties: _____
What type(s) of stressful events has your child experienced recently? _____
_____
What kinds of stressful events have family members experienced recently? _____
_____

CHILD'S EDUCATION

School (Name, Address)	Grade	Age	Teacher	Grades

CHILD'S DEVELOPMENT

Pregnancy and Delivery

Was this a planned pregnancy? ❑ No ❑ Yes
Was the mother under doctor's care? ❑ No ❑ Yes
Number of previous pregnancies/miscarriages: _____
Describe any complications that occurred during the pregnancy: _____
What drugs/alcohol/medications were used during the pregnancy? _____
At this child's birth, what was the mother's age? _____ Father's age?_____
Length of pregnancy: _____ weeks Birth weight: _____ lbs _____ oz
Length of labor: _____ Child's condition at birth: _____
Mother's condition at birth: _____
Length of stay in hospital: Mother _____ Child_____
Is this child adopted? ❑ No ❑ Yes (open or closed, please circle one)
If yes, please provide adoption history: _____
Was the child breast or bottle fed? ❑ No ❑ Yes
If yes, when was she/he weaned? _____
At what age was this child toilet trained? Days: _____ Nights: _____

Did bed wetting occur after toilet training? ❑ No ❑ Yes
If yes, until what age? _____
Did soiling occur after toilet training? ❑ No ❑ Yes If yes, until what age? _____
Describe sleep patterns or problems: _____
Language difficulties? ❑ No ❑ Yes
If yes, please describe: _____
Delays in child's walking? ❑ No ❑ Yes
If yes, please describe: _____
As a young child, did your child have problems getting along with others? ❑ No ❑ Yes
If yes, please describe: _____
Were there other problems experienced during the child's first year i.e attachment? ❑ No ❑ Yes
If yes, please describe: _____

Thank you for taking the time to complete this form as fully and accurately as possible.