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# Parent Intake

**A. Basic Information**

1. Child's name: ______________________________________ Birthdate: _______________Age: ___________
Person(s) completing this form: ____________________________________ Today's date: _______________
Relationship to child: __________________________________________Home phone:_______________________

Child resides at (Address):_________________________________________________________________________
Others living in the home (name, relationship)

_____________________________________________ _____________________________________________
_____________________________________________ _____________________________________________
_____________________________________________ _____________________________________________
_____________________________________________ _____________________________________________

Parents are currently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Other:
Family members not living at this address (name, relationship to your child):

_____________________________________________ _____________________________________________
_____________________________________________ _____________________________________________

**B. Reason for Seeking Services**

What is the main reason you are requesting counseling services for your child? What are you most concerned about at the present time?

What are your goals for treatment? Please be as specific as possible.

What is your child's understanding about why s/he is being seen for counseling and what will be occurring?

**C. Your Child and Family**

Tell me about the abilities and achievements that make you most proud of your child.

Tell me about the actions and problems that make you most concerned for your child.

Please tell about other immediate family members – the persons s/he interacts with on a regular basis.

Describe any other people, not mentioned above, who have significant contact with your child.

Please describe a typical weekday for your child: What does s/he do? Who does s/he interact with? What is the quality of those interactions?

Please share a bit about your philosophy, principles and beliefs about parenting.

Tell me about any special factors, such as family culture, languages, parenting and custodial arrangements, which would be helpful for me to know about:

Please tell me about any recent stresses and crises that have occurred in the family in the last few years. For any stress you list, describe how you think it may have affected your child. Example: Include a parent who must work unusually long hours in the list of stresses. Also, include any anticipated future stresses.

What do you think is your greatest strength as a parent (each parent)?

What do you think is your greatest limitation as a parent (each parent)?

Each parent: please describe the periods of time you spend with your child that provide you with the most satisfaction as a parent.

Please share about the periods of time that are the most difficult for you as a parent.

What experiences have been the most helpful to you as a parent?

Your child's special skills, talents and interests (hobbies, sports, recreational, musical, TV, toy preferences, etc):
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

**D. Early Development**

Age 0-2: please complete all that apply.

Problems experienced during pregnancy and delivery______________________________________
Birth complications or problems ________________________________________________________
Difficulty bonding______________________________________________________________
Medical/Health problems_________________________________________________________
Developmental delays___________________________________________________________
Sleep problems________________________________________________________________

Age 3-5: please complete all that apply:
Delay in speech/language development____________________________________________
Delay in motor development______________________________________________________
Difficulties with social interaction___________________________________________________
Sleep problems, night terrors_____________________________________________________

**E. Health/Medical History**

Primary Care Physician:_________________________________________________________
Conditions currently being treated: ______________________________________________

Medical History: check all that apply to your child. Please explain if yes.

| | | |
|---|---|---|
| Hospitalizations | no | yes:______________________________________ |
| Surgery | no | yes:______________________________________ |
| Major medical condition | no | yes:______________________________________ |
| Allergy | no | yes:______________________________________ |
| Seizure history | no | yes:______________________________________ |
| Infectious disease | no | yes:______________________________________ |
| Sleep problems | no | yes:______________________________________ |
| Feeding problems | no | yes:______________________________________ |
| Delays in development | no | yes:______________________________________ |
| Tobacco use | no | yes:______________________________________ |
| Substance use | no | yes:______________________________________ |
| Other | no | yes:______________________________________ |

Please list all medical and treatment providers:

| Name | Specialty | Purpose | Goals or Outcome | Active Patient? |
| --- | --- | --- | --- | --- |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please list all medications:

| Name of medication | dosage | purpose | prescriber |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**F. Mental Health History**

Please list all mental health diagnoses:

| Diagnosis: | By whom | When |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

Mental Health History: does your child have a history of any of the following? If yes, please explain:

Anxiety no yes:_______________________________________________
Depression no yes:_______________________________________________
Trauma no yes:_______________________________________________
Bullied no yes:_______________________________________________
Aggression no yes:_______________________________________________
Video gaming addiction no yes:_______________________________________________
Unusual thoughts no yes:_______________________________________________
Self-harm behaviors no yes:_______________________________________________
Suicidal ideation/behavior no yes:_______________________________________________
Homocidal ideation/beh. no yes:_______________________________________________
Inpatient mental health treatment no yes:______________________________________________
Outpatient mental health treatment no yes:_______________________________________________
Sexualized behavior no yes:_______________________________________________
Other no yes:_______________________________________________Has

**G. School**

Does your child attend school? Yes No Homeschooled Other:_________________________________
Name of school___________________________________________________________ Grade_________________
Are you satisfied with your child's school program? Yes☐ No☐ Not Sure☐
Is this an area you would like to discuss? Yes☐ No☐ Not Sure☐
Does your child qualify for special services? Yes☐ No☐ Not Sure ☐
If yes, please describe the services your child receives:

**H. Other**

In accordance with state law (*WAC 388-877-0640 (4)(a-c); WAC 388-877-0610 (2)(f-k)*), we are required to ask the following. Please check all that apply to your child:

| | | |
|---|---|---|
| Advanced mental health directive | no | yes |
| Advanced medical directive | no | yes |
| Court ordered treatment | no | yes |
| Under supervision by Department of Corrections | no | yes |
| Threat to self or others | no | yes |
| Gambling problem or addiction | no | yes |

______________________________________________________________________________

______________________________________________________________________________

Is there anything else I should know that doesn't appear on this form, but might be important for me to know about?

______________________________________________________________________________

______________________________________________________________________________

**-----------------------------------------------Stop Here-----------------------------------------------**

**Please bring your completed form to your first appointment**

For therapist use:

Date Services Were Requested______________________________Date of First appointment __________________

Assessment completed by____________________________________________Date________________________

*(Attach Addendum I to complete Intake Assessment)*

*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*

To request this information in an alternative format, please contact MindSource Center, 253-639-7146.

We will work with individuals requesting alternate formats, to ensure it is effective.