



CHILD / ADOLESCENT INTAKE FORM

Today's date: _____

Child's Name: _____

Date of Birth: _____ Age: _____ Grade: _____

Name of School: _____

Race/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 Name: _____ Relationship to Child: _____

Address: _____ City: _____

Prov: _____ Postal Code: _____ Home Telephone: _____

Other Phone (specify): _____ Email: _____

MOTHER'S INFORMATION

Mother's Name: _____ Date of Birth: _____

New Perspectives Counselling Ltd.
Caroline Krupica & Associates



Home Telephone: _____ Other Telephone (Specify): _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Race/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: _____



Race/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 is:

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 death? 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 problems? 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):

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

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/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

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.