GRYBA PHILLIPS PROFESSIONAL COUNSELLING ASSOCIATES

206-912 Idylwyld Drive North **Business: (306) 934-5898**
Saskatoon SK S7L 0Z6 **Facsimile: (306) 934-5812**

Child/Adolescent Intake Form

Name of Child:

_____
(Last) (First) (Middle Initial)

Date of Birth: _____ Age: ___ Grade: ___

Address: _____ Postal Code: _____

Parents/Caregivers: _____

_____

With whom does the child live? _____

Home phone: _____ Cell phone: _____ Work phone: _____
Messages ok? Yes No Messages ok? Yes No Messages ok? Yes No

Emergency contact and phone number : _____

Family Physician: _____ Referred by: _____

Siblings:

Name	Age	
_____	___	_____
_____	___	_____
_____	___	_____

What is your primary concern regarding your child?

_____

How long has this been a concern? _____

What help or supports have you already tried for this concern?

_____
_____

What are your goals for counselling regarding your child? _____
_____

What are your child's strengths? _____
_____

What are your child's interests? _____

What are your child's coping mechanisms? _____
_____

Please circle the letter that best describes your child or your child's situation for each question. Please feel free to add your own comments after each question if necessary.

1. How would you best describe your child's diet?
    a. A lot of fast food and sweets.
    b. Pretty good most of the time.
    c. Well balanced and nutritious almost all of the time.

2. How would you best describe your child's sleep habits?
    a. Does not get enough sleep, always seems tired.
    b. Gets enough sleep most of the time.
    c. Always gets enough rest.

3. How would you best describe your child's exercise habits?
    a. Has vigorous exercise once or twice a week.
    b. Has some exercise almost every day.
    c. Engages in vigorous exercise daily.

4. How would you best describe your child's television/video game/computer habits?
    a. 3 hours or more of TV/video games/computer per day.
    b. 2 to 3 hours of TV/video games/computer per day.
    c. 1 hour or less of TV/video games/computer per day.

5. How would you best describe your child's attitude towards learning?
    a. Complains about learning activities and/or school.
    b. Enjoys some types of learning and not others.
    c. Loves to learn and rarely experiences difficulty.

6. How would you best describe the discipline atmosphere in your child's home?
    a. Discipline is a challenge.
    b. The child responds to discipline most of the time.
    c. The child knows the rules of the house and does not break them.

7. How would you best describe the general atmosphere of your home?
    a. Schedules change frequently (meal times, bedtime, custody schedules, et cetera)
    b. The basic schedules of the home are pretty consistent.
    c. The schedules of the home rarely change.

8. How would you describe the emotional atmosphere of your home?
    a. Loud, in a fun, positive way.
    b. Loud, lots of fighting.
    c. Moderately quiet; we're not a talkative family.
    d. Lots of humor and good feelings.
    e. Some of all of the above.

9. How would you describe the incidence of emotional or behavioural problems in your child's extended family (includes problems with alcohol or drug abuse, behavior problems of children or teens, problems at work, mental illness, et cetera)?

10. If your child's parents are divorced, are the parents:
    a. Recently separated or divorced?
    b. Separated or divorced between six months and a year ago?
    c. Separated or divorced more than a year ago?

11. If your child's parents are divorced, how would you describe their current relationship?
    a. Poor. Frequent arguments and disagreements.
    b. Average. Most disagreements get settled quickly.
    c. Good. Few disagreements. Both parents are very involved in the child's life.

12. How would you best describe your child's physical type?
    a. Significantly smaller or heavier than other children of the same age.
    b. About average compared to children of the same age.
    c. Somewhat taller.

13. How would you best describe your child's temperament?
    a. Difficult and oppositional most of the time.
    b. Sometimes easy going, sometimes willful.
    c. Very easy going and cooperative.

14. How would you describe your child's general health?
    a. Frequent health problems and/or identified learning or physical problems.
    b. About average. No known physical or learning problems.
    c. Exceptionally healthy.

15. How would you describe your child's general language abilities (including reading) and reasoning abilities (including math)?
    a. Has frequent difficulty. Lags behind other children.

b. About average when compared to children of the same age.
c. Excels in these and other academic areas.

16. How would you describe your child's ability to engage in social relationships?
    a. Makes friends easily.
    b. Has one or two friends.
    c. Has no friends/spends most of his/her time alone.

17. Has your child had their hearing tested? Yes No
    If yes, are there any hearing problems?

18. Has your child had their sight tested? Yes No
    If yes, are there any sight problems?

Indicate which issues your child experiences by making a checkmark beside each that apply:

_____Anxiety /Panic Attacks
_____ Distracted/forgetful
_____ Complains of Pain (headaches, stomach aches, etc.)
_____ Startles easily
_____ Accident prone
_____ Difficulties with organizing, planning
_____ Isolated/detached from others
_____ Digestive problems/stomach aches
_____ Sensitivity to light and/or sounds
_____ Recurring dreams or nightmares
_____ Hyperactivity/restlessness
_____ Emotionally subdued
_____ Aggression
_____ Feelings of shame and/or guilt
_____ Exaggerated emotions
_____ Crying and irritable
_____ Stressed
_____ Bed wetting and/or soiling
_____ Temper tantrums
_____ Easily overwhelmed
_____ Self-harming behaviors (cutting, scratching, burning)
_____ Other (specify) _____

_____ Avoidance behaviour
_____ Attraction to dangerous situations
_____ Day dreaming
_____ Concentration difficulties
_____ Irritability
_____ Disrupted eating patterns
_____ Mood swings
_____Tired/tires easily
_____Difficulty falling or staying asleep
_____ Excessive worry
_____ Coordination difficulties
_____ Suicidal ideas
_____ Sexual problems
_____ Depressed
_____ Repetitive play
_____ Diminished curiosity
_____ Shy
_____ Coordination difficulties
_____ Clingy
_____ "I can't do it" attitude

_____

19. Is your child currently being treated for any medical or physical conditions?
    Yes No

If yes, identify the condition, and medications, and check below to identify who is involved in the treatment.

Condition_____

Medications:_____.

Involved in treatment:

❑ Family Physician ❑ Homeopath ❑ Massage therapist
❑ Naturopath ❑ Chiropractor ❑ Physical therapist
❑ Acupuncturist ❑ Occupational therapist ❑ Psychiatrist
❑ other : _____

History:

Which of the following has your child experienced? Please check all that apply. Please add additional comments below if necessary.

❑ Fetal distress
❑ Premature birth
❑ Fall (stairs/bed/trees/playground equipment/etc.)
❑ Broken bones
❑ Major injuries or burns
❑ Prolonged immobilization (casts, braces, etc.)
❑ Surgery
❑ Life threatening or severe illness
❑ Poisoning
❑ Medical procedures (ie. stitches)
❑ Lost
❑ Other _____
❑ Near drowning/suffocation
❑ Birth difficulties
❑ Auto/bike accidents
❑ Divorce/separation
❑ Death of significant individual or pet
❑ Witness to violence
❑ Abuse (verbal, physical, sexual)
❑ Loss of possessions (fire, flood, robbery, etc.)
❑ Dental procedures
❑ Bullying (school, neighbourhood, sibling)
❑ Exposure to extremes in temperature

Additional Information:

A copy of the current custody order has been provided: ❑ Yes ❑ No ❑ N/A

I understand that the treatment given is not a substitute for medical or psychological diagnosis. The practitioner does not diagnose conditions, nor prescribe or perform medical treatment.

Signature of Caregiver: _____ Date: _____

Witness Signature: _____