Refocus Together
Counseling Services

Client Intake Cover Page – Child

This form is required for your file. The information is needed for claims and/or auditing purposes. Please fill in all areas. **"Client"** refers to person seeking services refer to person seeking services.

Name of Person Completing this form: _____

Relation to the Child: _____

Phone: _____ Email: _____

Name of other parent/legal guardian: _____

Phone:_____ Email: _____

Emergency Contact (Name, Phone, & Relationship): _____

_____

Child's Full Name: _____

(Circle One) Male Female

Date of Birth: _____ Age ____

Client Address: _____

Who does the child live with? _____

Academic Information:
Name of Child's School: _____ Grade/Year_____

How did you hear about ReFocus Together? _____

GENERAL HEALTH INFORMATION:

1. Is the child currently taking any prescription medication (including psychiatric meds)?

( ) Yes ( ) No

Please list _____

2. How would you rate your child's current physical health?

MENTAL HEALTH INFORMATION:

3. Has the child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

( ) Yes ( ) No
If yes, previous therapist/physician:_____

Has the child ever been prescribed psychiatric medications?

( ) Yes ( ) No

If yes, please list and provide dates:_____

_____

4. Is the child experiencing overwhelming sadness, grief, or depression?

( ) Yes ( ) No

If yes, for how long? _____

5. Is the child experiencing anxiety, panic attacks, or any phobias?

( ) Yes ( ) No

If yes, when did this start? _____

6. Has the child experienced any trauma (molestation, abuse, death of a loved one, etc.)?

( ) Yes ( ) No

If yes, please explain_____

_____

7. What significant life changes or stressful events has the child experienced recently?

   _____

   _____

FAMILY MENTAL HEALTH HISTORY:

In this section below identify if there is a family history of any of the following.

Alcohol/Substance Abuse	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No
Depression	( ) Yes ( ) No
Domestic Violence	( ) Yes ( ) No
Eating Disorders	( ) Yes ( ) No
Obesity	( ) Yes ( ) No
Obsessive Compulsive Behavior	( ) Yes ( ) No
Schizophrenia	( ) Yes ( ) No
Suicide or Attempts	( ) Yes ( ) No

ADDITIONAL INFORMATION:

1. **History of the Problem**:

a. Please describe what concerns you have regarding your child: _____

   _____

b. How long has the problem existed? _____

c. What attempts have been made to resolve the difficulties? _____

   _____

2. Siblings? ( ) Yes ( ) No

If yes, what age are the siblings?

_____

_____

_____

3. Is your family considered to be spiritual or religious? ( ) Yes ( ) No

If yes, describe your belief:

_____

4. What do you consider to be your child's strengths? _____

_____

5. What would you like to accomplish with your child's time in therapy?

_____

_____
Printed Name of the Client Date

_____
Signature of the Client/Guardian Date