Psychological Services Clinic at UNC
serving the Greeley community for over 50 years

CHILD CLIENT INTAKE

Please provide the following information for our records. **Leave blank any question you prefer not to answer.**

Identification

Person(s) completing this form: _____ Today's Date: _____

Child's name in use: _____ Birth date: _____ Age: ___ Gender:_____

Pronouns: _____Address: _____

Guardian One: _____ Age: _____

Address: _____ Phone: _____

Occupation: _____

Relationship to child: _____ □ Biological □ Adoptive □ Step □Other:_____

Guardian Two: _____ Age: _____

Address: _____ Phone: _____

Occupation: _____

Relationship to child: _____ □ Biological □ Adoptive □ Step □Other:_____

Parents are currently: □ Married □ Divorced □ Remarried □ Never married □ Other: _____

If divorced: □ Joint custody □ Sole custody

Custody status: □ Custody resolved □ Custody evaluation in progress

□ Custody being contested □ Other: _____

Child is currently living with (names & relationship to child): _____

_____

Any other Guardians' Name(s): _____ Age(s): _____

Address: _____ Phone: _____

Occupation: _____

Family History

Please check all items which apply & explain (i.e. who [mother, father, extended family], when, circumstances, etc)

□ Previous counseling: _____
□ Current counseling: _____
□ Inpatient mental health treatment: _____
□ Suicide history and/or attempts: _____
□ Depression and anxiety: _____
□ Learning disabilities: _____
□ Abuse (physical, sexual, emotional): _____
□ Drug and/or alcohol abuse: _____
□ Serious illness/injuries: _____
□ Legal difficulties: _____
□ Other: _____

Siblings (use back of form for additional space, if needed)

Name in use Date of birth Description of relationships – how do they get along?

_____

_____

_____

_____

_____

Developmental History

Pregnancy and delivery

Problems during pregnancy? _____

Mother's age during pregnancy?_____ Father's age during pregnancy?_____

Did mother: □ Smoke? (number of cigarettes per day: _____)

□ Drink alcohol? (number of drinks per day/week: _____)

□ Use drugs? (what drug and how much: _____)

□ Experience illness during pregnancy? (_____)

Was child premature? (by how many days? _____) □ Labor induced? Length of labor? _____

Any other birth complications or problems? _____

Early development

Any problems with… □ Feeding □ Allergies □ Sleeping □ Medical □ Birth defects □ Personality

Any delays in… □ Saying single words □ Crawling □ Walking □ Talking □ Toilet training □ Fine-motor

Health

List all childhood illnesses, hospitalizations, medications, allergies, head traumas, significant accidents and injuries, surgeries, periods of loss-of-consciousness, convulsions/seizures, and other medical conditions.

Condition Age Treated by whom Consequences

_____

_____

_____

_____

Is your child currently taking any prescribed psychiatric medication (antidepressants or others)?

□Yes □No If yes, please list: _____

Residences

Homes

Dates From → to	Location	Living with whom	Reason for Moving	Any problems

_____

_____

_____

_____

Residential placements, institutional placements, or foster care

Dates From → to	Location	Living with whom	Reason for Moving	Any problems

Schools

School name and district	Child's age	Grade	Teacher

□ Significant academic problems: _____

□ Special education □ Retention (grade: ____) □ Speech/language therapy □ OT/PT □ IEP Plan

□ Significant behavior problems □ Detention □ Suspension □ Expulsion

□ Organized Sports: _____ □ Extracurricular Activities: _____

May I call and discuss this child with their current teacher? □Yes □No Contact: _____

Special Skills or Talents of Child

List hobbies, sports, recreation, TV, toy preference, etc:

_____

_____

_____

History of Abuse

Describe any history of neglect or verbal, emotional, physical, or sexual abuse: _____

_____

_____

_____

What actions were taken? _____

_____

_____

Previous Psychological Concerns and Counseling History

Please describe: _____

_____

Name(s) of previous counselor(s): _____

Dates and types of therapy (e.g. individual, family, etc): _____

Impact/ outcome/ results of therapy: _____

_____

Have you ever had thoughts of suicide or self-harm? □Yes □No

If so, please describe: _____

Current Concerns

Describe all current psychological, emotional, behavioral and educational problems and concerns: _____

_____

_____

_____

Describe your current relationship(s) with your guardians: _____

_____

Do you have any concerns with eating, sleep, or substance use you would like to discuss? □Yes □No

Treatment

What would you like to achieve through therapy?: _____

_____

How do you hope therapy might change things for you? _____

_____

What would you like to achieve through therapy for the family? _____

_____

What questions do you have about therapy? _____

_____

Other

What else might be important to share that might not appear on this form?

_____

_____

_____

_____

_____

_____

_____

Master's and doctoral students in our graduate programs staff the Psychological Services Clinic (PSC). To ensure the quality of services you receive, all counselors in training are assigned faculty supervisors with whom to consult concerning the progress of counseling. Your session may be both audio and visually recorded. The purpose of recording is to provide instruction and feedback to students. All recorded materials and written records are restricted to the internal use of the PSC and their confidentiality will be strictly safeguarded, with exceptions discussed with your counselor in the first session. Recordings are deleted after 90 days.