REACHING PEACE COUNSELING
PSYCHO-SOCIAL FAMILY INTAKE

TODAY'S DATE: _____

CHILD'S NAME_____ Age_____ DOB_____

CURRENT SCHOOL _____ GRADE _____

OTHER SCHOOLS ATTENDED:

SCHOOL NAME GRADE/S ATTENDED REASON FOR LEAVING PERFORMANCE

_____
_____
_____
_____
_____

FAMILY INFORMATION

Was child adopted? If so, please describe the circumstances_____
_____
_____

Please list the members of the client's current household:

NAME	**RELATIONSHIP TO CHILD**	**AGE**

Other relatives not living with the child, i.e. biological father or mother, stepsisters or brothers:

Family Medical History (please list significant medical or genetic disorders that are known with the child's biological parents_____
_____

Is there a family history of the following? Please check:

		Birth Mother's side	Birth Father's side
1.	Problems with attention		
2.	School learning problems		
3.	School behavior problems		
4.	Bi-Polar disorder		
5.	Depression		
6.	Substance/Alcohol Abuse		
7.	Addictions		
8.	Anxiety or panic attacks		
9.	Autism Spectrum Disorder		
10.	Suicide attempt/s		
11.	Neglect or abuse		
14.	Attention Deficit Disorder with or without Hyperactivity		
15.	Criminal involvement		
16.	Unusually high or low IQ		

CHILD'S INFORMATION

PRENATAL & PREGNANCY HISTORY

1. Mother smoked cigarettes? Yes _____ No

2. If yes, how many cigarettes a day on average?

3. Mother drank: wine_____ beer_____mixed drinks_____ ?
   How many days a week on an average?
   How many drinks at a time on an average?

4. Mother used drugs? Yes _____ No _____ If yes, which ones?
5. Mother had bleeding? Yes _____No _____ When during pregnancy?
6. Mother was on prescribed medication during pregnancy? Yes _____ No _____
   If yes, which medications?

7. Check any medical conditions mother had during pregnancy:
   _____Loss of consciousness _____ High blood pressure _____ Low blood pressure
   _____ Diabetes _____ Toxemia _____ Nutritional deficiency
   _____ Emotional problems _____ Other (specify)

PERINATAL/NEONATAL HISTORY

1. Age of mother at birth _____ Age of father at birth _____

2. Was pregnancy full term? Yes _____ No
   If premature, how many weeks?

3. Labor was _____easy _____average _____difficult?

4. Birth was _____head first _____breech _____cesarean?
   If Cesarean, why?

5. Were forceps used? Yes _____ No

6. Birth weight was:_____ pounds, _____ ounces

7. Did baby have breathing problems at birth? Yes _____ No
   If yes, was oxygen given? Yes_____ No
8. What was the Apgar score?

9. Check any medical conditions baby had at birth:

   _____ Head trauma _____ Hemorrhage
   _____ Blood disorders (anemia) _____ High sodium (hypernatremia)
   _____ Low calcium (hypocalcemia) _____ Low temperature (hypothermia)
   _____ Pneumonia _____ Jaundice: mild_____ severe
   _____ High blood glucose (hyperglycemia) _____ Convulsions, fits
   _____ Infections: type

10. Baby was discharged from hospital along with mother after _____ days.
    If baby remained hospitalized after mother's discharge, how many days?

EARLY CHILDHOOD HISTORY (0-3 YEARS)

1. Approximate age the baby sat up along _____ Walked _____ First single words
   First phrase

2. Did the baby have allergies? No_____ Yes_____ To what?

3. Did the baby have any problems at bedtime? No_____ Yes
   If yes, what problems?

4. Did the baby have any problems with eating? No_____ Yes
   If yes, what problems?

5. Baby was _____Under-active _____Over-active _____Easy _____Difficult
   _____Anxious _____Cranky _____Calm _____Happy

6. Did the baby have frequent infections? No_____Yes
   If yes, what kinds and how severe?
7. Did the baby have fevers over 104 degrees? No _____ Yes
   If yes, did the high fevers seem to change the baby in any significant way?

8. Was the baby hospitalized? No_____ Yes_____ At what age(s)?
For what reasons and how successful was hospitalization?

9. Did the baby sustain any significant head injuries? _____ Periods of unconsciousness?
Seizures?_____ Please explain answers

10. Did the toddler have: _____ Speech disturbances _____Clumsiness
_____Act as if difficulty understanding spoken language
_____Hearing problems _____Vision problems _____Hyperactivity?

11. At what age was your child successfully toilet trained? _____ Was training _____difficult _____easy

12. Were there serious marital problems during this period? No_____ Yes

13. How did the child react to these problems?

PRESCHOOL HISTORY (3-5 YEARS)

1. Did the child suffer any serious illness during these years? No_____ Yes

2. Was the child _____Accident prone _____Clumsy_____Uncoordinated
_____ Inattentive _____Hard to discipline _____Unhappy
_____Anxious _____ Overly aggressive _____Disinterested in peers

3. Was the child **Overly Sensitive to:** (circle those below that apply)

Sound Smells Tactile stimulation Sights Tastes

4. Did the child attend _____Preschool? _____Nursery? _____Kindergarten?

5. Was there a significant separation anxiety at preschool or nursery or kindergarten? No_____ Yes_____

6. Were there problems with learning?No_____ Yes
If yes, what were these problems?

7. Were there problems getting along with other children? No_____ Yes
If yes, what were these problems?

8. Was the child considered difficult? No_____ Yes_____
If yes, explain:

9. Did the child have significant problems getting along with brothers and sisters? No_____ Yes
If yes, explain:

10. Did the parents have serious marital problems during this period? No_____ Yes

11. How were the marital problems manifested in the home (yelling, physical violence) and how did the child react to the parents' problems?

12. Did your child lose control of his/her bladder repeatedly (following toilet training) during the day? No_____ Yes
Did your child lose control of his/her bladder repeatedly (following toilet training) during the night? No_____ Yes
Did your child lose control of his/her bowels (following toilet training) during the day? No_____ Yes

13. Did your child develop unusual vocal or body motor tics? No_____ Yes_____ At what age? _____ If they went away, at what age did they go away? _____ Do they still persist? No _____ Yes

CHILD/ADOLESCENT HISTORY

1. MEDICAL AND ACCIDENT HISTORY (Check the items that apply)

_____ Asthma	_____ Seizures	_____ Arthritis
_____ Allergies	_____Diabetes	_____ High fevers/convulsions
_____ Nosebleeds	_____ Tonsillitis	_____ Frequent vomiting
_____ Vision Problems	_____ Hives/Eczema	_____ Frequent headaches
_____ Hearing Problems	_____ Overweight	_____ Fainting/blackouts
_____ Ear Infections	_____ Underweight	_____ High blood pressure
_____ Heart murmur	_____ Constipation	Other (specify)
_____ Rheumatic fever	_____ frequent diarrhea	
_____ Dizzy spells	_____ Bronchitis	

2. Explain any physical disabilities:

3. Explain any significant accidents, injuries or operations:

4. Explain any special education or services:

a.	Resource room	grade/s_____	Academics _____
b.	Speech therapy	grade/s_____	Name of therapist_____
c.	Occupational therapy	grade/s_____	Name of therapist_____
d.	Social skills classes	grade/s_____	Name of therapist_____
e.	Educational tutoring	grade/s_____	Name of tutor_____

5. When your child was young (less than 10 years old) was he/she:

				Now if child is over 10	
a.	Fidgety, squirmy	No _____	Yes _____	No _____	Yes
b.	Restless	No _____	Yes _____	No _____	Yes
c.	Impulsive	No _____	Yes _____	No _____	Yes
d.	Poorly attentive	No _____	Yes _____	No _____	Yes
e.	Easily distracted	No _____	Yes _____	No _____	Yes
f.	Unable to remain seated	No _____	Yes _____	No _____	Yes
g.	Talking excessively	No _____	Yes_____	No _____	Yes
h.	Difficult to Discipline	No _____	Yes _____	No _____	Yes

6. Has your son/daughter:

a.	Stolen more than once	No _____	Yes_____	Ages
b.	Run away from home more than once	No _____	Yes_____	Ages
c.	Lied often	No _____	Yes _____	Ages
d.	Set fires	No _____	Yes _____	Ages
e.	Been truant from school at least several time	No _____	Yes _____	Ages
f.	Deliberately destroyed other's property	No _____	Yes _____	Ages
g.	Broken into someone's house	No _____	Yes _____	Ages
h.	Been physically cruel to animals	No _____	Yes _____	Ages
I.	Used a weapon in a fight	No _____	Yes _____	Ages
j.	Had more than one physical fight with peers	No _____	Yes _____	Ages
k.	had Juvenile Court involvement	No _____	Yes _____	Ages

If yes, when and what were the charges?

Names of probation officer/court worker: _____

7. Has your child:

a.	Repeatedly lost his/her temper	No _____	Yes _____	Ages
b.	Often argued with adults	No _____	Yes _____	Ages
c.	Often defied or refused adult requests or rules	No _____	Yes _____	Ages
d.	Deliberately annoyed other people	No _____	Yes _____	Ages
e.	Blamed others for his/her mistakes	No _____	Yes _____	Ages
f.	Been easily annoyed by others	No _____	Yes _____	Ages
g.	Been angry and resentful	No _____	Yes _____	Ages
h.	Been spiteful and vindictive	No _____	Yes _____	Ages
I.	Sworn a lot or used obscene language	No _____	Yes _____	Ages

8. Does your child have:

a.	Excessive or unrealistic worry about future events	No _____	Yes _____	Ages
b.	Excessive concern over past behaviors	No _____	Yes _____	Ages
c.	Excessive concern about his/her competence (Athletic, academic, social)	No _____	Yes _____	Ages
d.	Complaints of headaches or stomachaches	No _____	Yes _____	Ages
e.	A lot of self-consciousness	No _____	Yes _____	Ages
f.	Tension and difficulty relaxing	No _____	Yes _____	Ages
g.	Gets stuck on thoughts	No_____	Yes_____	Ages
h.	Excessive need for reassurance from others	No _____	Yes _____	Ages

9. Does your child have:

a.	Difficulty with social interaction	No _____	Yes _____	Ages
b.	Unusual social communication	No _____	Yes _____	Ages
c.	Rigid behaviors	No _____	Yes _____	Ages
d.	Repetitive behaviors	No _____	Yes _____	Ages
e.	Gets stuck on same thoughts	No _____	Yes _____	Ages
f.	Difficulty understanding friendly teasing	No _____	Yes _____	Ages
g.	Unusual obsessions	No _____	Yes _____	Ages
h.	Resists changes in routine	No _____	Yes _____	Ages
i.	Difficulty with social cues and clues	No _____	Yes _____	Ages
j.	Unusual response to sensory experiences	No _____	Yes _____	Ages

10. Has your child:

a.	Had excessive fear of weight gain	No _____	Yes _____	Ages
b.	Had excessive weight loss	No _____	Yes _____	Ages
c.	Felt fat when he/she isn't	No _____	Yes _____	Ages
d.	Dieted excessively	No _____	Yes _____	Ages
e.	Used laxatives, diuretics	No _____	Yes _____	Ages
f.	Self-vomited after meals	No _____	Yes _____	Ages

11. Has your son or daughter used:

a.	Alcohol	No _____	Yes _____	Occasionally _____	Frequently
b.	Marijuana	No _____	Yes _____	Occasionally _____	Frequently
c.	Cocaine	No _____	Yes _____	Occasionally _____	Frequently
d.	Sedatives, hypnotics	No _____	Yes _____	Occasionally _____	Frequently
e.	Hallucinogens or ecstasy	No _____	Yes _____	Occasionally _____	Frequently
f.	Inhalants	No _____	Yes _____	Occasionally _____	Frequently
g.	Other (explain)				

12. Has your son or daughter:

a.	Had a significant depressed (sad) mood	No _____	Yes _____	Minor _____	Major
b.	Been less interested in most activities	No _____	Yes _____	Minor _____	Major
c.	Gotten less pleasure than usual from activities he/she enjoys	No _____	Yes _____	Minor _____	Major
d.	Lost a good deal of weight	No _____	Yes _____	Minor _____	Major
e.	Complained of or had a lack of appetite	No _____	Yes _____	Minor _____	Major
f.	Been unusually tired and listless	No _____	Yes _____	Minor _____	Major
g.	Had difficulty falling asleep at night	No _____	Yes _____	Minor _____	Major
h.	Had difficulty remaining asleep at night or waking earlier than normal	No _____	Yes _____	Minor _____	Major
i.	Felt guilty or worthless (low self-worth)	No _____	Yes _____	Minor _____	Major
j.	Had difficulty concentrating in school or at home	No _____	Yes _____	Minor _____	Major
k.	Mentioned suicide or felt like dying	No _____	Yes _____	Minor _____	Major
l.	Attempted suicide	No _____	Yes _____	Minor _____	Major
m.	Been more withdrawn than usual	No _____	Yes _____	Minor _____	Major

13. To your knowledge, has your child been sexually victimized (fondled, sexually abused, raped)? No _____ Yes
If yes, at what age(s) _____ And by whom?

14. Was your child ever physically or emotionally abused? No _____ Yes
If yes, at what age(s) _____ And by whom?

15. Please describe, as best you can, your child's personality (emotional makeup). Be as descriptive as you can:

16. Please describe what forms of discipline you have tried and how successful or unsuccessful your methods have been. Do both parents discipline the same way. Are you consistent in your handling out of consequences? What do you use as a consequence?

17. Has your son or daughter been provided mental health treatment in the past? No _____ Yes _____

Describe:_____
_____
_____
_____

18. Has your son or daughter ever had a psychiatric or psychological evaluation or been tested by a school psychologist for special education services? No _____ Yes

Describe:_____
_____
_____
_____

19. Current stress situations in the past year: (please check)

_____ Death
_____ Divorce/Separation
_____ Family violence
_____ Other (specify)
_____ Financial
_____ Remarriage
_____ Visitation
_____ Custody problems
_____ Family member illness
_____ High frequency moving

20. Please list any medications your child is currently taking:

Name of Medication	Dosage/Time	Doctor Prescribing the Drug
1.		
2.		
3.		
4.		
5.		
6.		

Other issues or problems not addressed: