



Licensed Professional Counselor
Registered Play Therapist

Child Intake Form

Child's Name _____ Age _____ Birth date _____

Referred by: _____

Child's Address _____

Mother's/Guardian's Name _____ Age _____ %

Circle one: Living with child Not living with child

Mother's Phone _____ E-mail _____

Education _____ Occupation _____

Employed currently? Circle one: Yes No

Father's/Guardian's Name _____ Age _____ %

Circle one: Living with child Not living with child

Father's Phone _____ E-mail _____

Education _____ Occupation _____

Employed currently? Circle one: Yes No

Parents are:

Single Married Partnered Separated Divorced Widowed

If child is not living with parent(s), please explain circumstances:

Family has many meanings. Who are the members of your child's family/household?

Name	Age	Relationship
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If you are divorced/separated, how old was your child when you separated? _____

If divorced, what is the custody arrangement?

Complications during pregnancy?

Circle one: Full-term Premature

Child's weight at birth? _____ lbs. _____ oz.

Child's health at birth? _____

Postpartum depression? Circle one: Yes No

Prenatal substance exposure? If so, which substances? _____

Is child adopted? Yes No

If so, what type of Adoption? Domestic International Foster

Is child in foster care? Yes No Previously

If child is adopted or in foster care, at what age was child removed from biological parent's care? _____

What were the circumstances of child's adoption/foster placement?

What have you told your child about his/her adoption/foster placement?

Does your child have any contact with birthparent(s)?

Was your infant: Calm Fussy Colicky Easily comforted Hard to comfort

Any difficulties with: Feeding Sleeping Bonding

Other? _____

Was any of the following present during the first few years?

Did not enjoy cuddling Difficult to comfort Excessive restlessness Frequent head banging

Was not calmed by being held Colic Excessive irritability Constantly into everything

Have you been told your child has a delay in any of these areas?

Speech or Language Motor Skills Social Skills Cognitive Sensory Behavioral Emotional Social

Does your child have any special needs?

Does your child receive any special services (i.e.: IEP, Speech, Occupational Therapy, Behavior Therapy, etc.)?

As best you can remember, list age of development:

Walked without assistance _____

Spoke first words _____

Toilet trained daytime _____

Toilet trained nighttime _____

Rate your child on the following skills (Good, Average, or Poor):

Walking _____ Running _____ Throwing _____ Catching _____

Shoelace tying _____ Writing _____ Athletic abilities _____

Do you consider your child to understand directions and situations as well as other children his/her age?

How would you rate your child's overall level of intelligence?

Below Average Average Above Average

Does your child have any health issues or allergies?

Does your child take any medication? (Give name/dose/frequency)

Have any of the following changes occurred in your child's life? (Please give dates)

Separation/Divorce of parents Parent's remarriage/new partner Parent incarcerated

Death of a family member Job loss/New job of parent Death of a pet

Birth/Adoption of a sibling Serious illness (child) Move to a new home

Prenatal Substance Exposure Serious illness (family member) Separation from parent

Sexual Abuse Physical Abuse Verbal Abuse

Car Accident Parental Substance Abuse Other traumatic experience

How do you think this event impacted your child?

One word that describes my child is...

“ _____ ”

What does your child like to play?

Does your child demand a lot of adult attention? Yes No

Describe: _____

Does your child usually play: alone w/ siblings w/peers w/ younger children

w/older children w/adults

Does your child attend school? What grade and school? Is your child currently in childcare? When/Where?

What are your child's strengths?

How does your child respond to stress?

How do you respond when your child is upset?

What kind of discipline works best with your child?

Please circle which of the following apply to your child:

Irritable/Moody Nervous/Anxious Depressed Doesn't seem to enjoy things used to

Excessive crying Fearful Easily bored Low self-esteem

Trouble concentrating Inability to focus Suicidal Panic Attacks

Difficulty sleeping Sleeps a lot Nightmares Drug use Alcohol use

Eats too much Eats too little Argumentative Low-self esteem

Please give an overview of what concerns you most about your child:

Has anyone in the child's family had a similar personality or problem?

What do you hope your child will gain from play therapy?
