Rebecca Brunette, LCSW #28550. 732 3rd St., Ste A, Davis, CA. 95616. (530) 902-2248

Child Intake: Please complete the following information, as it will help me in planning and providing appropriate services for your child.

Child's Name: _____ Date: _____
Date of Birth:_____ Age:_____ Referred by:_____
Grade: _____ School: _____
How did your child adjust to going to school?

_____
Is your child in any special education program, or magnet school?

_____
Parent 1
Name:_____
Address: _____
Home phone: _____ Cell: _____
E-mail_____
Occupation:_____
Parent 2
Name:_____
Address (if different than above):_____
Home phone:_____Cell:_____
E-mail: _____
Occupation:_____

Relationship status of parents:_____
Please list all other family members or others living in your home(s):

Name(s)	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Were there any complications with your child's pregnancy?

_____
Was your child exposed to any substances during pregnancy? (alcohol, illicit drugs, prescription medications, tobacco, caffeine, etc.?)

_____
Were there complications during delivery, or birth?

_____
What age did your child walk? _____What age was your child toilet trained? _____
Speak first words?_____ Did the mother have post-partum depression?_____
Child's Physician (name, phone, address):

_____
Has your child ever been diagnosed with a serious illness? If yes, please describe:

_____
Please list any health/medical conditions for which your child is receiving treatment:

Allergies or Asthma? _____
Please describe your child's overall health today:

_____

Is your child experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe:_____

_____

Please check any of the following areas in which your child may be having difficulty:

_____Headaches _____Sadness _____ Anger _____Dizziness _____ Obsessions
_____Aggression _____Isolation _____Fainting _____Compulsions _____Relationship issues
_____Nausea _____Loneliness _____Anxiety _____Trauma _____Always tired
_____Decreased appetite _____Racing thoughts _____Hopelessness _____Hyperactivity
_____Increased appetite _____Fatigue _____Frequent Urination _____Impulsivity _____ Tics
_____Insomnia _____Bowel disturbance _____Elevated mood _____Increased sleep
_____Hallucinations _____Mood swings _____Nightmares _____Paranoia _____Hearing voices
_____Panic Attacks _____Anorexia/Purging _____Suicidal thoughts _____Suicidal actions
_____Cutting _____Homicidal thoughts _____Feel like crying _____Can't keep friends
_____Feel tense _____Distrust of others _____Lack of interest _____Feel worthless
_____Blurred vision _____Flashbacks _____Stomach trouble _____Decreased need for sleep
_____Conflict with parents/siblings _____Recent weight gain/loss
_____Excessive checking, list-making, washing _____Smelling things others don't smell
_____Verbal, emotional, physical, sexual abuse _____Victim of Violent Crime

Do you think your child smokes? If yes, how much?_____
Do you think your child drinks alcohol? If yes, how much/often?_____
Do you think your child takes drugs? If yes, what kind and how often? _____
Please list any medications your child is taking: _____
Please list any medications your child has taken in the past:_____
Has your child been in therapy, or had psychiatric help of any kind in the past? If yes, please describe:_____
Has your child ever had psychological testing in the past? If so, with whom?

_____

Has your child ever attempted suicide? If yes, please describe:_____
Please describe your child's interest and hobbies:_____
What do you see as your child's strengths?

_____

_____

Briefly describe concerns which brought your child to therapy:

_____

_____

Is there anything else you think it would be important for me to know about your child?

_____

_____

_____