The Family Changes Play Therapy Clinic
28580 IH-10 West, Ste 4
Fair Oaks Ranch, Texas 78015

210.202.1999 (office)

888.723.1795 (fax) *www.familychangesplaytherapy.com*

INTAKE FORMS

Please provide the following information and answer the questions below:

Client Name:

_____

(Last) (First) (Middle Initial)

Birth Date: ___/___/___ Age: _____ Gender: ___M/___F

Name of Parent/Guardian (if under 18 years):

Name: _____

(Last) (First) (Middle Initial)

Marital Status:

___Never Married ___Domestic Partner ___Married
___Separated ___Divorced ___Widowed

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: () May we leave a message? Y N
Cell/Other Phone: () May we leave a message? Y N

Email:_____May we email you? Y N

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

RESPONSIBLE PARTY:

Name: _____

(Last) (First) (Middle Initial)

Birth Date: ___/___/___ Age: _____ Gender: ___M/___F

Relationship to Client: _____ Employer: _____

Insurance ID#: _____ Group ID#: _____

Insurance Company: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION:

I authorize The Family Changes Play Therapy Clinic to contact the following person in case of an emergency:

Emergency Contact Name: _____

Relationship to Client: _____

Contact Number(s): _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

CHILD INTAKE FORMS

Behavioral strengths:

What does your child do that you like?

What does he/she do that other people like?

What do you do together that is nurturing? (Physical, social, spiritual, emotional)

_____

Behavioral Excesses:

What does your child currently do too often /get him/her in trouble?

Please list all the behaviors you could think of.

_____

What method of discipline do you use for your child to create accountability?

_____

Treatment Goals: From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST?

Medical History:

What is the name of your child's medical doctor?

_____**Address:** _____

Phone: _____

Date of your child's last medical examination: _____

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

No _____
If yes, previous therapist/practitioner: _____

Did your child receive a mental health diagnosis?

No
If Yes_____

Has your child ever been prescribed psychiatric medication?

No
If yes, please list and provide dates: _____

Psychiatrist_____

Last seen on_____

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco or alcohol?

No
Yes, please list and describe: _____

Did the child's mother have any problems during the pregnancy or at delivery?

No
Yes, please list and describe which ones: _____

Did the child's mother smoke tobacco use any alcohol, drugs or medication during pregnancy?

No
Yes, please list and describe which ones: _____

Family History:

The name of the child's biological parents:

Mother: _____ Father: _____

Who have legal guardianship of your child? _____

Who does your child currently live with? _____

Names	Ages	Relationship to Child	Grade/Job
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Who are your child's significant others NOT living with your child?

Names	Ages	Relationship to Child	Grade/Job
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Education History:

What school does your child attend? _____

Address: _____ Phone: _____

Teacher's Name: _____ Current Grade: _____

What does your child's teacher say about him/her?

Other schools attended (including Pre-school)

_____

Has your child ever repeated a grade? _____ If so which one(s)_____

Has your child ever received any type of special-education services?

Has your child experienced any of the following problems at school?

Fighting Lack of Friends Drug/Alcohol Detention
Suspension Learning Disabilities Poor Attendance Poor Grades
Gang Influence Incomplete Homework Behavior Problems

Has your child experienced any of the following medical problems?

A Serious Accident Hospitalization Surgery Asthma
A Head Injury High Fever Convulsions/Seizures
Allergies Meningitis Hearing Problems
Ear/Eye Problems Loss of Consciousness
Other_____

Has your child ever been hospitalized?

No

If yes, when and when

_____

Please list any current medical problems or physical handicaps:

_____

Please list any medications your child takes on a regular basis:

No

If yes, please list dosage and frequency: _____

Other History:

Has your child ever experienced any type of abuse (physical, sexual or verbal)?

No
Yes, please list and describe which ones: _____

Has your child ever made a statement/s of wanting to hurt him/herself or seriously hurt some one else?

No
Yes, please list and describe which ones: _____

Has he/she purposely hurt himself or another?
No
Yes, please list and describe which ones: _____

Has your child ever experienced any serious emotional losses (such as a death of physical separation from a parent or another caretaker)?

No
Yes, please list and describe which ones: _____

Is there any thing else you would like to address that is currently stressful to your child and his/her family?

_____