

Children's (0-5 years old) Psychosocial Intake Form

Source of Information

- Child Interview/Observation
- Parent/Caregiver Interview
- Parent/Caregiver Self-Report form
- Prior mental health record(s)
- Standardized tests/instruments (specify) _____
- Other (list) _____

Presenting Problem

What is the presenting problem as described by the parent/caregiver. _____

Services requested by: Parent/Caregiver DHS Court PCP Other _____

Parents/Caregivers expectation for recovery: _____

History of presenting problem:

When was this first noticed? _____
 How often is the problem occur? _____
 How severe is the problem? _____
 Context of problem: _____

Has this child been in counseling before?

Yes No If so, please describe who, when and the results:

Is this client involved with outside agencies or service providers such as Child Welfare, DHS, Courts, School providers? Yes No

If so, please describe who, when and the results:

Strengths of Child

- Socially engaging
- Curious/interested
- Seems bright
- Is Affectionate
- Has at least one positive relationship with an adult
- Follows directions
- Shares excitement/interests with peers or adults
- Other _____

Strengths of family/caregiver(s)

- Realistic expectations for child
- Motivated to help child
- Able to tune-in to child
- Family warmth
- Support within family unit
- Effective communication
- Adequate financial resources
- Able to advocate for child
- Involved in community

Please rate your child on each behavior. Write the number that matches the frequency of the behavior using the following scale: 1 = Never 2 = Occasionally 3 = Frequently

Name of responder: _____

A. 0-18 months

1. Crying that is excessive in intensity or duration
2. Persistent arching, floppiness, or stiffening when held or touched
3. Cannot be consoled by caregiver
4. Cannot fall asleep or stay asleep
5. Does not vocalize (i.e.coo), cry or smile
6. Fails to initiate interaction or does not respond to caregiver (turns away from caregiver's face; does not make/maintain eye contact; interaction with others does not appear to be pleasing; unresponsive to caregiver's attempts to engage; generally appears withdrawn or uninterested; flat affect)
7. Does not respond to environment (e.g., appears listless, uninterested, nonresponsive)
8. Persistent and excessive feeding problems (refuses to eat; eating only certain foods)
9. Persistent and excessive sleeping problems (e.g., sleeps less than 8 hours)
10. Unaware or uninvolved with surroundings
11. Does not explore environment or play
12. Does not seek out caregiver to meet needs (solace, play, object attainment, does not look at or seek out caregiver when hurt or distressed; does not play or accept help from caregiver)

B. 18-36 months

1. Any of the behaviors listed above for 0 – 18 months
2. Destructive, disruptive, dangerous or violent behavior (e.g., Physically attacks peers, siblings, or caregiver; intentionally and repeatedly breaks toys)
3. Excessive or frequent tantrums (daily tantrums lasting over an hour or multiple tantrums daily, tantrums involve destructive or injurious behavior; frequent tantrums that appear unpredictable)
4. Aggression despite reasonable adult intervention
5. Repetitive self-injurious behavior (e.g., head banging repeatedly pinching or scratching self) or self-stimulating behavior (e.g., rocking, masturbation)
6. Makes suicidal statements (e.g., I wish I was dead, I'm going to kill myself) or suicidal gestures (e.g., lying in the street, tying rope around neck, stabbing self)
7. Appears to have an absence of fear or awareness of danger (e.g., climbs on bookshelves or refrigerator; runs into street; leaves parent while in community)
8. Fails to initiate interaction or share attention with others with whom she/he is familiar
9. Few or no words, fails to respond to verbal cues (doesn't try to communicate; unresponsive to caregiver's attempt to communicate with word or gesture)

C. 3-5 years

1. Any of the behaviors listed for 0 – 36 months
2. Frequent night terrors (wakes frequently at night, difficulty falling asleep, may include sense of fear)
3. Preoccupation with routines, objectives, or actions (e.g., hand washing-becomes distraught if interrupted; tantrums if objects in house moved or routine disrupted)
4. Hyperactivity (e.g., won't sit still as if "motor running;" moves from activity to activity)
5. Accident-prone (e.g., bumps into things and doesn't seem to notice)
6. Repeated cruelty to animals (repeatedly squeezes, hits, kicks, throws, or drops animals; kills animal)
7. Lack of concern or regard for others
8. Problem behavior in toileting (e.g., constipation, smearing, urinating in specific places [not bathroom])
9. Aggression (e.g., biting, kicking, property destruction, unpredictable aggression)
10. Does not use sentences of 3 or more words; speech is unintelligible
11. Withdrawn, does not play or interact with peers (may actively avoid peers).
12. Poor coordination of movement (clumsy, sits or lays on objects without appearing to realize it)
13. Clear and significant loss of previously gained skills (no longer talks, no longer toilet trained)

Family History

Has the child ever been homeless? Yes No
 Is there any family history of mental illness? Yes No
 Have any family members ever been affected by substance use or abuse issues? Yes No
 Has the child been away from parent for an extended period? Yes No
 Has there been family stress or family conflict? Yes No
 Has the family used community resources? Yes No
 For any yeses, please provide details:

Has the child experienced trauma? (e.g., multiple or repeated events that threaten child's sense of safety: physical/sexual abuse, witness to domestic violence, severe physical neglect; Single but significant traumatic event: fire, death of caregiver/significant person, dog attack, car accident, shooting) Yes No If yes, please provide details and how the child was affected.

Please list everyone who lives at the same residence as the child.

	<u>Name</u>	<u>Age</u>	<u>Relationship</u>
1.			
2.			
3.			
4.			
5.			
6.			

Please list family members living outside the home.

	<u>Name</u>	<u>Age</u>	<u>Current living address</u>	<u>Relationship to child</u>
1.				
2.				
3.				

Client name: _____

DOB: _____

Medical Information

Has the child seen a doctor within the last year?

Yes No

If so, what was the reason for the visit?

Name of child's medical provider

Name _____

Is the child taking any medications, prescriptions, or over-the-counter medications? Yes No

If so, please list:

Medication	Dosage	Reason
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Please list any major medical problems that the child has had (chronic illnesses, serious illnesses, operations, injuries or trauma to the head?)

Does the child have any allergies?

Yes No

If so, what?

Has the child lived around someone who uses tobacco?

Current Suspected Past No

Has the child lived with people who have used alcohol to excess regularly?

Current Suspected Past No

Has the child ever ingested alcohol?

Current Suspected Past No

Has the child lived with people who have used recreational or illegal drug use?

Current Suspected Past No

Has the child has ingested recreational, illegal, or nonprescribed drugs?

Current Suspected Past No

Client name: _____

DOB: _____

Developmental History

Were there any problems with the pregnancy or delivery of the child? Yes No
If so, do you know what those problems were?

Has the child had a recent developmental assessment? Yes No If so, what were the results?

Briefly describe the child's relationship to both parents

Briefly describe the child's relationship to siblings.

Briefly describe the child's temperament.

Preschool History Please check here if not applicable

When did the child start school? _____ Were there any problems when the child started school? Yes No If so, what were the problems?

What problems have come up during the years?

How does the child get along with his or her teachers?

How does the child get along with his or her friends or peers in school?

What are the child's favorite school activities?

What subjects or activities does the child have problems with?