L. Gordon Psychotherapy
2718 Telegraph Avenue, Ste. 210
Berkeley, CA 94704
510-761-5609
MFT#50459

MINOR CHILD INTAKE FORM

Parent/Guardian please complete this form so that the most comprehensive service can be provided for your child. If you aren't sure how to answer a question, leave it blank and discuss it with the counselor.

Child's Name:_____
D.O.B.: _____ **Age:** ____ **S.S.#**_____
Gender: _____ **Male** _____ **Female** _____**Transgender Identified (**____**MTF** ____**FTM)**

What brings your child to therapy? _____
_____
_____

Please check the severity of the concerns/problems: __mildly upsetting __moderately severe __very severe __extremely severe __incapacitating
Additional comments:_____

Other Children in household?(names/ages):_____
_____

Grade/School:_____
How is your child doing academically?_____

How is your child doing in school behaviorally?_____
_____

Does your child have a learning or physical disability? __Y __N __Maybe. Specify:
_____

School #(school or teacher contacted only with your permission): (___) --

Ethnic/Cultural Background (optional): _____

Spiritual Practice/Religious Affiliation (optional):_____

Whom have you previously consulted about your child/adolescent's present problems? What happened?_____
_____

Does your child have a mental health diagnosis? __Y __N. Please specify: _____
_____

Medical History
During pregnancy, did mother use: __ Cigarettes __ Alcohol __ Drugs __ Experience Extreme Stress?
Specify frequency, amounts, and duration:_____
_____
List any birth complications (Ex: Premature, jaundice, C-section, etc.)_____
_____
List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)
_____
_____
Does child use: __ Cigarettes __ Alcohol __ Drugs __Inhalants __Prescription Drugs
Specify substance, amount and frequency:_____
Primary Physician: _____ **Phone:**_____ **Last seen:** _____

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Psychiatrist: _____ Phone:_____ Last seen: _____
Current medications: (Include dosage and frequency):_____
_____
Allergies: _____

During first two years, did your child experience: __Separation from mother __Out of home care __Disruption in bonding __Depression of mother __Abuse __Neglect __Chronic pain __Chronic Illness __Parental Stress If yes, please specify: _____
_____
_____
Reached developmental milestones: __On time __Early __Late
How many times has the child moved homes?_____
What are five adjectives that describe:
Mother: _____
Father:_____
Child: _____
Parental Relationship:_____

Family History
Biological Dad:_____ Biological Mom:_____
___/___/___ Married; ___/___/___ Separated; ___/___/___ Divorced

Siblings (1st to last):
Name: _____ Age:___ Name:_____ Age: ____
Name: _____ Age:___ Name:_____ Age: ____
Name: _____ Age:___ Name:_____ Age: ____

Child Custodian (If not biological parents):
Name: _____ Name: _____ Date became caretaker:_____
People in household, if different from above: _____
_____
Does father work outside the home? __Y __N Occupation: _____ Hours:___
Father's highest level of education: _____
Does mother work outside the home? __Y __N Occupation: _____ Hours:___
Mother's highest level of education: _____
If separated or divorced, visitation schedule: _____
What is custody arrangement regarding physical and mental health care: _____
_____
Does either parent have legal issues? _____
List history of mental illness or addiction in immediate or extended family (Ex: ADHD, Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, PTSD, schizophrenia, etc.):
_____
_____
_____
Have children witnessed domestic violence? __Y __N, Specify: _____
_____
How is your child disciplined? Please list each method and frequency of use:
_____

Trauma History
Has your child been verbally abused? __Y __N __Suspected. Specify:

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_____Has your child been physically abused? __Y __N __Suspected. Specify:

_____

_____

Has your child been sexually abused? __Y, __N, __Suspected. Specify:

_____

_____

Other stressors or traumas?_____ Have children exposed to community violence? __Y __N, Specify:

_____

Has your child/adolescent experienced any significant loss(es)? If yes, explain:

_____

Check the symptoms your child/adolescent displays:
__Anger __Anxiety __Bed wetting __Acts out sexually __Conduct problems __Controlling Defecation
__Has unusual sexual knowledge __Day wetting __Defiance __Depression __Homicidal thoughts
__Disassociates actions __Drug or alcohol use __Hyperactivity __Masturbates excessively
__Hypervigilance __Impaired conscience __Isolation
__Lack of empathy __Lack of motivation __Lethargy __Low impulse control __Plays out violent theme
__Low self-esteem __Lying __Nightmares __Bullying acts
__Plays out sexual themes __Obsesses __Over/Under eating Phobias __Peer problems __Phobias
__Running Away __Extreme shyness __Sleeplessness __Stealing __Tantrums __Somatic Symptoms:
Headaches/Stomach aches, etc. __Refuses to attend school
Other:_____
List the number of times per week symptoms are displayed:

_____

How does your child/adolescent handle anger?_____

_____

Your child/adolescent 's major strengths and positive traits?_____

_____

Your child/adolescent's hobbies?_____
What are your child/adolescent's responsibilities at home? _____

_____

How well does your child/adolescent's handle these responsibilities? _____

_____

Briefly describe your goals for your child/adolescent's therapy: _____

_____

Please list any information you deem to be important for the therapist to know:_____

_____

Who shall I contact in case of emergency?
Name: _____ Phone (___) - Relationship: _____
Name: _____ Phone (___) - Relationship: _____

I hereby consent for Loretta Gordon, MFT to provide my child/adolescent with evaluation and participate in therapy.

_____
Parent/Guardian Signature Date

_____
Therapist Signature Date