

**Crossroads Counseling Associates
11154 Huron Street Suite 209
Northglenn, CO 80234**

CHILD INTAKE EVALUATION/HISTORY

Child's Name _____ Age _____ DOB _____

Name of School _____ Grade _____

Parent's Name _____

Address _____ Phone Number(s) _____

Major presenting concerns and surrounding events/situations/traumas

DEVELOPMENTAL HISTORY

Complications during pregnancy/childbirth YES _____ NO _____
If YES, please explain _____

Normal development (walking, talking, going to bathroom, etc...) YES _____ NO _____
If NO, please explain _____

Any developmental delays _____

MEDICAL HISTORY

Currently taking any medications YES _____ NO _____
If YES, please list _____

Date of last medical exam and any findings _____

Hospitalizations/Major Surgeries and Dates _____

Other major medical concerns/issues/considerations

SCHOOL HISTORY

Any problems with teachers/authority figures YES _____ NO _____
Any problems with other children YES _____ NO _____
Any suspensions YES _____ NO _____
Learning difficulties YES _____ NO _____

If YES to any question, please explain _____

Is the school/your child's teacher aware of any current problems the child is having or your concerns YES _____ NO _____

If YES, would you be willing to sign a consent for the therapist to speak with the school counselor or your child's teacher YES _____ NO _____

SOCIAL HISTORY

Does your child play independently YES _____ NO _____
Does your child play cooperatively with others YES _____ NO _____
Does your child have a special friend/group of friends YES _____ NO _____
Does your child isolate him/herself when in groups YES _____ NO _____

List your child's favorite activities _____

EMOTIONAL/BEHAVIORAL HISTORY

Current emotions your child has difficulty expressing _____

Current emotions your child expresses inappropriately _____

Acting out behaviors _____

Concerning behaviors _____

PREVIOUS COUNSELING SERVICES

3 GOALS FOR YOUR CHILD IN COUNSELING

1) _____

2) _____

3) _____

3 GOALS FOR YOURSELF/SPOUSE DURING COUNSELING

1) _____

2) _____

3) _____

SPIRITUAL HISTORY

SUPPORT FOR YOU/YOUR CHILD/YOUR FAMILY DURING THIS TIME

Client signature

Date

Therapist signature

Date