family service

counseling • support • compassion

Name of Child: _____ Form Filled out by:_____

Date:_____ Relationship to child:_____

Has This Child...

Been a victim of physical abuse?	☐ Yes	At what age?_____ By whom?_____
Been the victim of sexual abuse?	☐ Yes	At what age?_____ By whom?_____
Been the victim of emotional and verbal abuse?	☐ Yes	At what age?_____ By whom?_____
Witnessed domestic violence?	☐ Yes	At what age?_____ By whom?_____
Been the victim of a crime?	☐ Yes	At what age?_____ What crime?_____ By whom?_____
Been in a car or other accident?	☐ Yes	At what age?_____
Experienced a medical emergency?	☐ Yes	At what age?_____ Describe:_____
Been in a hurricane, tornado or bad storm?	☐ Yes	At what age?_____
Had someone close to them die?	☐ Yes	At what age?_____ Who died?_____
Been terrified or very upset by another event?	☐ Yes	At what age?_____ Describe event(s):_____ _____ _____ _____

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Child/Teen Client Information and History Form

Today's Date: _____

First Name: _____ Last Name: _____

Preferred Name: _____

In an emergency, we can contact: _____ Emergency phone number: _____

Please describe your concern(s) about your Child/Teen /family that bring you here to today:

_____

_____

_____

_____

Where else have your turned for help (family, friends, church, school, other agencies)?

_____

_____

Has your Child/Teen received counseling before? ☐ Yes ☐ No

If yes, what type of counseling services did your Child/Teen receive (Where and When)? _____

_____

Have you been to Family Service before? ☐ Yes ☐ No

If yes, when, with whom, & what services were provided? _____

_____

Are you interested in receiving information about other services & programs that Family Service of Waukesha can provide? ☐ Yes ☐ No

Current Stressors - Please check all that apply to your current situation:

		Comments	*Therapist Comments*
School	☐ Yes ☐ No		
Peers	☐ Yes ☐ No		
Family	☐ Yes ☐ No		
Parent's Separation / divorce	☐ Yes ☐ No		
Grief due to loss of a loved one	☐ Yes ☐ No		
Accident	☐ Yes ☐ No		
Community Violence	☐ Yes ☐ No		
Other:	☐ Yes ☐ No		

Suicide Evaluation

Does your Child/Teen think about harming themselves or ending their life? ☐ Yes ☐ No

If yes, does your Child/Teen have a plan? Please explain.

Has your Child/Teen ever attempted suicide? ☐ Yes ☐ No

If yes, please explain. Include date, method, and any treatment they received as a result.

Does your Child/Teen think about harming someone else or ending their life? ☐ Yes ☐ No

If yes, towards whom? And do you have a plan? Please explain.

Has your Child/Teen ever intentionally harmed or attempted to harm another person? ☐ Yes ☐ No

If yes, whom? Also, please explain.

Pregnancy, birth and delivery:

Was this a planned pregnancy?	☐ Yes ☐ No
Did you receive regular prenatal care?	☐ Yes ☐ No
Were there any medical complications?	☐ Yes ☐ No
Did you take any medications?	☐ Yes ☐ No
Did you use cigarettes/tobacco?	☐ Yes ☐ No
Did you use alcohol?	☐ Yes ☐ No
Did you use any other drugs?	☐ Yes ☐ No
How was the birth and delivery?	

Infancy:

Sleeping problems?	☐ Yes ☐ No
Eating problems?	☐ Yes ☐ No
Did they like being held in the first year?	☐ Yes ☐ No
Did they cry a lot in the first year?	☐ Yes ☐ No
When they cried, were they easy to calm down?	☐ Yes ☐ No
Did they seem pretty active?	☐ Yes ☐ No
Compared to other babies, were they difficult to hard to care for?	☐ Yes ☐ No

Developmental Milestones: (please make your best guess)		**Comments**
When did they begin to crawl?	months	
When did they begin to walk?	months	
When did they begin to use single words?	months	
When did they begin to talk in sentences?	months	
When did they complete toilet training?	years	
How was your Child/Teen 's temperament or "personality" as an infant and toddler (mood, alertness, sociability, etc.)		

Have you believed your Child/Teen was developing more slowly than other Child/Teen ren in any area (physical, speech, cognitive, social, etc.?) ☐ Yes ☐ No If yes, please explain:

_____

_____

Has your Child/Teen ever been assessed for developmental concern? ☐ Yes ☐ No If yes, please explain:

_____

Currently

How is your Child/Teen's mood most of the time now?
Where do they sleep?
How do they sleep?
How is their appetite?
Has there been any recent change in their sleep, appetite, interest in activities, or daily routine?
Does your Child/Teen have any current toileting issues? ☐ Yes ☐ No If yes, explain:

Friendships – Please check any items that apply to your Child/Teen

Too few friends	☐	Plays mostly with younger Children	☐
Regularly talks/plays with friends	☐	Often gets into fights with friends	☐
Is overly shy	☐	Withdrawn from friends	☐
Makes friends easily	☐	Finds it hard to keep friends	☐
Others seem to picking on my Child/Teen	☐	Is mean to friends	☐
Has enough friends	☐	Hangs out with a "bad" crowd	☐

Medical History

Does your Child/Teen have or ever had any of the following:		*Any comments?*	*Therapist comments*
Allergies	☐ Yes ☐ No		
Arthritis	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No		
High or low blood pressure	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No		
Digestive problems / ulcers	☐ Yes ☐ No		
Headaches	☐ Yes ☐ No		
Head injury	☐ Yes ☐ No		
Hearing problems	☐ Yes ☐ No		
Heart disease	☐ Yes ☐ No		
Incontinence / bed wetting	☐ Yes ☐ No		
Kidney problems	☐ Yes ☐ No		
Liver disease (e.g. hepatitis)	☐ Yes ☐ No		
Neurological problems (e.g. seizures, epilepsy)	☐ Yes ☐ No		
Gynecological problems	☐ Yes ☐ No		
Thyroid problems	☐ Yes ☐ No		
Vision problems	☐ Yes ☐ No		
Miscarriage / abortion	☐ Yes ☐ No		
Currently pregnant	☐ Yes ☐ No ☐ Maybe		

Please list any other medical problems or conditions: _____

_____

_____

Previous Hospitalizations/Surgeries

Please list any medications your Child/Teen is currently taking. Also, please state what they are used for. (Please include herbal, over-the-counter, & prescribed items)

Prescription name (or herbal name):	***For:***	***Prescribed by:***

How would you rate your Child/Teen 's your overall health?

☐ Excellent ☐ Very good ☐ Good ☐ Not very good

How often do you worry about your Child/Teen 's health?

☐ Never ☐ Rarely ☐ Occasionally ☐ Often

Other Behaviors:		***Comments***	***Therapist comments***
Do you know of, or suspect any caffeine, cigarette, alcohol or any other drug use by your Child/Teen?	☐ Yes ☐ No		
Do you know of, or suspect any sexual activity by your Child/Teen?	☐ Yes ☐ No		
Does your Child/Teen have any access to guns or other weapons?	☐ Yes ☐ No		

At times it is important for us to communicate with other people involved with your Child/Teen and family in order to know how to best help. We will only do so with your written permission (or whoever is the Child/Teen's legal guardian) and in cooperation with you.

Primary Care - Physician Information

Physician's name:			
Name of practice:		Phone #:	
Address:			
May we communicate with your Child/Teen's pediatrician?	☐ Yes ☐ No ☐ I want to discuss this with the therapist first.		

Please list the names of your Child/Teen's teacher and any other school personnel involved (school social worker, IEP teach, guidance counselor, etc.)

May we communicate with your Child/Teen's school?	☐ Yes ☐ No ☐ I want to discuss this with the therapist first.

Please list the names of anyone else who may be involved in working with your Child/Teen and family whom it might be important for us to communicate with (relatives, clergy, social worker, attorney, etc.)

Household Information: Please list below family and other household members:

Name	***Gender***	***Age***	***How related to your Child/Teen?***	***Living with your Child/Teen?***	***Adult: Employer & Occupation Child/Teen: School & Grade***
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Does anyone in your family have a problem with alcohol or drug use? ☐ Yes ☐ No

Does anyone in your family have a mental health problem? ☐ Yes ☐ No

If yes to any above, please explain:

Current Symptoms or Problems

Symptom/problem description	***'X' if currently a problem.***	***How long has it been a problem?***	***Any comments?***	***Therapist comments***
Sadness	☐			
Irritability / anger	☐			
Weight change	☐			
Change in appetite	☐			
Sleep pattern changes	☐			
Guilt feelings	☐			
Feeling hopeless	☐			
Feelings of worthlessness	☐			
Difficulty concentrating	☐			
Difficulty making decisions	☐			
Loss of interest in activities once enjoyed	☐			

Symptom/problem description cont.	*'X' if currently a problem.*	*How long has it been a problem?*	*Any comments?*	*Therapist comments*
Decreased sexual drive	☐			
Fatigue, loss of energy	☐			
Poor self-esteem	☐			
Memory problems	☐			
Depression	☐			
Thoughts of suicide or death	☐			
Thoughts of harming another	☐			
Worrying a lot	☐			
Feeling anxious	☐			
Fear of losing control	☐			
Feelings of panic	☐			
Feelings that you're having a heart attack	☐			
Numbness or tingling	☐			
Fear of social situations	☐			
Seeing or hearing things that others do not	☐			
Episodes of times you can't remember	☐			
Thoughts that bother you	☐			
Beliefs that others do not agree with	☐			
Behaviors that bother you	☐			
Difficulty being alone	☐			
Difficulty in relationships	☐			
Self-injury behavior	☐			
Risky or reckless behavior	☐			
Feelings of unreality / being detached from self	☐			
Repetitive behaviors (such as hand-washing, ordering, counting, or checking)	☐			
Recurring dreams	☐			
Flashbacks after an event	☐			

Symptom/problem description cont.	*'X' if currently a problem.*	*How long has it been a problem?*	*Any comments?*	*Therapist comments*
Distinct periods of inflated self-esteem, excessive spending, goal-directed activity, or racing thoughts	☐			
Persistent difficulty with fidgeting, feeling on the go, interrupting others, talking too much, or having impatience	☐			
Persistent difficulty with forgetfulness, sustaining attention, or completing tasks	☐			
Less effective at home, school, or work	☐			

Personal History

Please explain any special considerations due to age, gender, sexual orientation, disability, culture, race, ethnicity, or religion:

Has your Child/Teen experienced any of the following?

Emotional abuse ☐ Yes ☐ No Sexual abuse ☐ Yes ☐ No Physical abuse ☐ Yes ☐ No

If yes, please explain.

Has your Child/Teen ever witnessed verbal aggression or physical fighting? ☐ Yes ☐ No

If yes, please explain.

Legal History

Has your Child/Teen ever been in trouble with the law? ☐ Yes ☐ No

Is your Child/Teen currently involved in the criminal justice system? ☐ Yes ☐ No

If yes, please list name of offense, date, and sentence information.

List any previous arrests. (Include date, offense, and sentence.)

Treatment Goals

What changes would you like to see as a result of the services your Child/Teen receives? Beginning with the most important goal, please indicate three goals.

1.

2.

3.

Please describe the specific changes in your Child/Teen's life that will be signs that things are improving:

List the barriers that have interferred with change so far, including personal weaknesses or limitations?

Please describe your Child/Teen's personal strengths, assets, and accomplishments, including those they have used to help overcome previous difficulties.

Please Stop When You Get Here ☺

Completed by Family Service Staff
Intake Assessment

Presenting Problem/ Symptoms:

Client Strengths and Supports Recent Changes to Support System:

Important psycho-social or contextual factors:

Diagnostic Criteria (DSM-5):

Principal Diagnosis		
Other		
Other		

Developmental Level			**Developmental considerations**
Behavioral	☐ Appropriate	☐ Inappropriate	
Cognitive	☐ Appropriate	☐ Inappropriate	
Emotional	☐ Appropriate	☐ Inappropriate	
Physical	☐ Appropriate	☐ Inappropriate	
Social	☐ Appropriate	☐ Inappropriate	
Other:	☐ Appropriate	☐ Inappropriate	

Mental Status Evaluation

Appearance	☐ appropriate	☐ well-groomed	☐ inappropriate	☐ disheveled	☐ bizarre
Orientation	☐ fully-oriented	☐ not fully-oriented (describe:)		☐ normal	☐ impaired
Speech	☐ relevant ☐ loud	☐ normal ☐ precise	☐ logical ☐ soft	☐ slow	☐ incoherent ☐ rapid/pressured
Affect	☐ appropriate	☐ inappropriate	☐ flat	☐ tearful	☐ constricted ☐ agitated
Activity Level	☐ Appropriate		☐ Inappropriate		
Cooperation	☐ Appropriate		☐ Inappropriate		
Engagement	☐ Appropriate		☐ Inappropriate		
Eye Contact	☐ Appropriate		☐ Inappropriate		
Thought process	☐ intact ☐ blocked	☐ abstract ☐ concrete	☐ loose associations ☐ circumstantial	☐ vague ☐ flight of ideas	☐ tangential
Thought content	☐ normal ☐ confusion	☐ paranoia ☐ delusions	☐ obsessions ☐ hallucinations	☐ other:	
Intelligence	☐ above average	☐ average	☐ below average		
Mood	☐ appropriate ☐ angry	☐ sad ☐ irritated	☐ anxious ☐ euphoric	☐ panicky ☐ despairing	☐ depressed ☐ bored
Motor Activity	☐ normal ☐ aggressive	☐ overactive ☐ compulsive	☐ under-active ☐ seductive	☐ other:	
Attitude	☐ cooperative	☐ uncooperative	☐ guarded	☐ suspicious	☐ belligerent
Reliability	☐ appears to be truthful		☐ appears to minimize	☐ appears to exaggerate	
Insight	☐ above average	☐ average	☐ limited	☐ absent	☐ unable to assess
Judgment	☐ good	☐ poor	☐ unable to assess		
Harm to Others Thought/Intent	☐ absent	☐ present	If present, complete harm to others plan below		
Suicidal Thought/Intent	☐ absent	☐ present	If present, complete suicide safety plan below		
Suicide Risk:	☐ Yes ☐ No		If yes, complete FSW 'No Harm Contract'.		

AODA – Substance Use/Abuse ☐ Current ☐ Past ☐ N/A

_____Describe _____

Past/Current trauma ☐ No ☐ Yes Describe_____

_____

_____

Referrals _____

_____

Genogram:

***Therapist Attestation**: My signature indicates thatI have completed a mental health assessment sufficient to determine client's need for outpatient treatment,and reviewed and discussed all information collected and contained herein".*

Therapist Signature	Date
Signature of Supervisor (trainees/supervisory protocol)	Date

Peer Review (all new cases must be presented within 30 days of intake) Date _____

Date of initial staffing:_____ Date VOCA completed:_____