Sea Change, LLC

CHILD INTAKE ASSESSMENT

Child's Name: _____ Date:_____

Age: _____ DOB: _____ Nickname: _____

Person to alert in the event of medical emergency:_____

Relationship to child: _____

Behavioral Excesses:

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

_____

_____

_____

_____

_____

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

_____

_____

_____

_____

_____

Behavioral Assets:

What does your child do that you like? What does he /she do that other people like?

_____

_____

_____

_____

_____

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: and how much must they change for you to be satisfied?

1.

2.

3.

_____

_____

_____

_____

Completed by: Date:

Please provide the following information about your child:

Family History:
The name of the child's biological parents:

Mother:_____ Father:_____
Who has legal guardianship of your child?

Who does your child currently live with?

Names	**Ages**	**Relationship to child**

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

Names	**Ages**	**Relationship to child**

Please describe any past counseling that either your child or any family member has had.

_____
_____
_____
_____
_____

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____ If yes, Please describe:

_____
_____
_____
_____
_____

Education History:
What school does your child attend?
Address:
Phone:_____ Teachers Name:_____
Current Grade:_____

Completed by: Date:

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 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	

Medical History:

What is the name of your child's medical doctor?_____
Address: _____ Phone:_____
Date of your child's last medical examination:_____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Completed by: Date:

Did the child's mother have any problems during the pregnancy or at delivery? If so, Please describe them:

Any developmental issues:

Has your child experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness	Other	

Please list any current medical problems or physical handicaps:

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

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Completed by: Date:

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

Has he/she ever purposely hurt himself or another? If yes to either question, please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?

Other:

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.

Completed by: Date:

RISK ASSESSMENT

1. Current suicidal ideation: _____
   _____
   _____

   i. Current plan:
   ii. Current means:

2. Past History of suicidal ideation or attempts (when and how)_____
   _____
   _____
   _____

3. Current homicidal ideation: _____
   _____
   _____

   i. Current plan:
   ii. Current means:

4. Action recommended and/or taken: _____

Mental Status Exam

Appearance: Grooming: ____Normal ____Disheveled ____Unusual
Hygiene: ____Normal ____Body Odor ____Bad Breath

Motor Activity: ____Relaxed ___Restless ____Pacing ____Sedate
____Threatening ___Catatonic ___Posturing
____Mannerisms ___Psychomotor retardation
___Psychomotor agitation ___tremors ___Tics

Attitude: ____Cooperative ____Oppositional/Resistant
____Defensive ____Other: _____

Speech: ____Normal ____Pressured ___ Slow ___ Dysarthric ____Apraxia
Expressive Language: ____Normal _____Circumstantial _____Anomia
____Paraphrasia ____Clanging ____Echolalia
____Incoherent _____Neologisms
Receptive Language: ____Normal ____Abnormal: _____

Mood: ____Normal _____Euphoric _____Elevated ____Depressed
____Angry _____Irritable _____Anxious

Completed by: Date:

Affect:	____Normal ____Reactive ____labile ____ depressed ____anxious ____Tearful ____Blunted _____Flat ____Constricted
Orientation:	____normal ____abnormal:_____
Estimated IQ:	_____Above Average _____Average _____ Below Average
Attention:	_____Normal ____Inattentive ____Distracted _____Hypervigilant
Concentration:	_____Normal _____Brief
Memory:	_____Normal ____abnormal
Thought Process:	____Goal Directed and Logical ____Circumstantial ____Confabulation ____Flight of Ideas _____Ideas of Reference ____Grandiosity _____Paranoia _____Magical Thinking ____Obsessions _____Preservation _____Delusions
Thought Content:	_____Suicidal Ideation: Thoughts, Intent, Plan _____Homicidal Ideation: Thoughts, Intent, Plan
Sleep:	_____Insomia, Hypersomnia, frequently waking up _____# hours of sleep per night
Hallucinations:	_____None ____auditory _____visual ____Olfactory
Judgement:	_____Good ____Fair ____Poor _____TBA
Insight:	_____Good ____Fair ____Poor _____TBA
Impulse Control:	_____Good ____Fair ____Poor _____TBA

Preliminary Diagnosis:

_____

_____

Recommendations for treatment:

Individual	family	sibling	group
psychological testing			
Inpatient	outpatient		
Play therapy	CBT	Solution-focused	EMDR
mindfulness	Goal oriented	Person-Centered	Family therapy
Frequency:	Weekly	Every other week	Monthly

_____

Kimberly A. Popkey, MA, LPC, CEDS, SEP

Completed by: Date: