Wellspring Psychotherapy Center
Child Intake Form

Child's Name: _____ Age: _____ DOB: _____
Sibling: _____ Age: _____
Sibling: _____ Age: _____
Sibling: _____ Age: _____
Sibling: _____ Age: _____

Mother's Name: _____
Address (City, State and Zip):
_____ Marital Status:
_____
Phone: (H)_____ (W)_____ (C)_____
Email _____
Occupation_____ Employment status_____

Father's Name: _____
Address (City, State and Zip): _____
Marital Status: _____
Phone: (H)_____(W)_____ (C)_____
Email_____
Occupation_____ Employment status_____

Step Parent(s)/Guardian(s): _____
Address (City, State and Zip): _____
Marital Status: _____
Phone: (H)_____ (W)_____(C)_____
Email _____
Occupation_____ Employment status_____

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History of Problem
Please describe what concerns you have regarding your child.

How long has the problem existed?

What attempts have been made to resolve the difficulties?

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, or financial problems, in the last several years?

Has your child had any trauma?

What are your child's greatest strengths?

Are you currently having trouble controlling your child's behavior ?

Please check the symptoms that the child is currently experiencing. Please indicate the duration, and severity.

SYMPTOM	HOW LONG	SEVERITY (0, 1, 2, 3) None, Mild, Moderate, Severe
Sadness or Depression		
Suicidal Thoughts		
Sleep Problems		
Changes in Appetite		
Weight Change		
Inability to Concentrate		
Obsessive thoughts		
Compulsive behaviors		
Panic Attacks		
Daytime wetting		

SYMPTOM	HOW LONG	SEVERITY (0, 1, 2, 3) None, Mild, Moderate, Severe
Bed Wetting		
Tension and Anxiety		
Feelings of Hostility		
Aggression		
Stomach Aches		
Headaches		
Fears or Phobias		
Friendship Issues		
Tics		
other-		

Social Media/Electronics Use

Average number of hours per week your child spends:

Playing computer or video games, X-box, etc. _____
Types of games played: _____

Watching TV/ Videos: _____

Other Child Information

School: _____ Grade: _____ Teacher: _____

Current Grades/Academic Performance: _____

_____

Extracurricular Activities:_____

Has your child had any psychological or academic evaluations ? If yes, what were the major findings:

_____

_____

History of psychotherapy: _____

_____

Significant medical problems: _____

_____

Serious illnesses, accidents, or surgeries in the past: _____

_____

Any significant prenatal history:_____

_____

Medications currently prescribed _____

Pediatrician: _____

Psychiatrist: _____

Other Agencies/Providers Helping Your Child Currently: _____

_____

Family History

For parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)

If adopted, does child know of adoption? Yes / No. Age at adoption? _____

Mother:
Significant Medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychotherapy : _____

Current prescribed medications: _____

_____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

_____

History of alcohol/drug use: _____

Father:
Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychotherapy: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

History of alcohol/drug use: _____

Step-parent/Guardian:
Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications:
_____

Current alcohol/drug use (amount, how often, intoxication frequency):

_____

History of alcohol/drug use: _____

Other vital family history:

_____

_____

_____

_____

_____