CHRISTINA R. SINCLAIR, PH.D.

CHILD INTAKE FORM (ages 5-13)
To be completed by Parent

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

1. Parent's Name: _____ DOB: _____
Address _____
(City, State and Zip): _____
Marital Status:_____ Male / Female
Phone: H(____)_____W(____)_____ C(____)_____
OK to say Dr. Sinclair? Yes _____ No_____
Emergency contact (name and phone #) _____

2. Parent's Name: _____ DOB: _____
Address _____
(City, State and Zip):_____
Marital Status:_____ Male / Female:
Phone: H(____)_____W(____)_____ C(____)_____
OK to say Dr. Sinclair? Yes _____ No_____
Emergency contact (name and phone #)_____

3. Step Parent(s)/Guardian(s):_____ DOB: _____
Address: _____
City, State and Zip: _____
Marital Status:_____ Male / Female
Phone: H(___)_____ W(___)_____ C ( )_____
OK to say Dr. Sinclair? Yes _____ No_____

Emergency contact (name and phone #)_____

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History of Problem

Please describe what concerns you have regarding your child:
_____
_____
_____
_____
_____

How long has the problem existed?
_____

_____

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

_____
_____
_____
_____

What attempts have been made to resolve the difficulties?

_____
_____
_____

Please check the symptoms that the child or family members are currently experiencing.

Please indicate to which family member you are referring, as well as duration, and severity.
Severity of symptom: None (0) Mild (1) Moderate (2) Severe (3)

Symptom	**Name(s)**	**How Long?**	**Severity**
Sadness or Depression			
Suicidal Thoughts			
Sleep Problems			
Changes in Appetite			
Weight Change			
Inability to Concentrate			
Obsessive thoughts/behaviors			
Tension and Anxiety			
Panic Attacks			
Memory Problems			
Compulsive Behaviors			
Feelings of Hostility			
Acts of Violence			
Social Isolation			
Strange Thoughts			
Stomach Aches			

Head Aches

Symptom	Name(s)	How Long?	Severity

Bed Wetting

Phobias

Other

Family History

Are there any agencies involved with the family (DCFS, Child Welfare, Courts, etc)?
_____
_____

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

Is ex-spouse (biological parent) aware that you are bringing their children to therapy? Yes No
If not, please explain _____

If adopted, does child know of adoption? Yes No N/A
What age was your child at the time of the adoption? _____

Mother
Occupation: _____ Employment status: _____
Employer's name: _____
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):_____
_____
_____

Father
Occupation: _____ Employment status: _____
Employer's name: _____
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):_____
_____

_____

Step-Parent/Guardian's Name: _____ DOB: _____
Occupation: _____ Employment status: _____
Employer's name: _____
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):_____
_____
_____

Child Information:

Child lives with:_____

School:_____Grade:_____ Teacher: _____
Any recent changes in grades? Yes No Explain: _____
History of special classes or evaluations: _____

History of psychiatric treatment or counseling:_____
_____
Significant medical problems:_____
Serious illnesses, accidents, or surgeries in the past:_____
_____
Medications currently prescribed:_____
Pediatrician:_____ Contact number: _____
Psychiatrist: _____Contact number: _____

What are some of your child's strengths? _____
_____
_____

What goals or outcomes would you like your child to receive from therapy?
_____
_____
_____