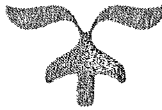
CONFIDENTIAL

Name: ____



Child Intake

Please read and answer the following questions. Information provided will be discussed during your initial meeting with your therapist.

Presenting Information

What are your primary concerns?

____

____

____

When did these concerns first start?

____

How have you or your family been trying to cope/manage?

____

____

What changes, stresses or losses have occurred in the past 1-2 years?

____

____

____

Mental/Emotional Health History

Has your child ever received counseling of any type? ___Yes ___No

Has your child received services with this agency prior to this date? ___ Yes ___ No

Has your child been hospitalized for mental health or drug/alcohol treatment? ___ Yes ___ No

If yes, please explain and provide dates:

____

Past providers and dates of services:

____

Has anyone in the family been diagnosed with mental health or emotional illness? ___ Yes ___ No

If yes, explain:

____

Michael Burke, Psy.D. & Associates, P.C

Symptoms Checklist

Please rate each symptom below using the scale provided. (No Concerns=0, 1, 2, 3, 4, 5= Major Concern)

Depressed __ Sleep Disturbance __ Anxiety/Agitation __ Obsessions __ Paranoia __

Suicidal Ideations ___ Substance Abuse __

Has your child ever experienced thoughts of suicide? __Yes __No

In the past 2 weeks has your child thought of suicide? __Yes __No

Has your child ever attempted suicide? __Yes __ No

Medical History

Who is your child's Primary Care Doctor? ______________________________

Place of Practice? ______________________________

Do you take any medications? __ Yes __ No

Medication	Dosage:	Treating:

Please list any chronic illness, disabilities, medical conditions that your child has been diagnosed with:

Illness/Disability	Dates:

Has your child ever experienced any type of abuse (physical, sexual, or emotional)? If yes, please explain.

____

____

Has your child ever made a statement of wanting to hurt him/herself or seriously hurt someone yes? If yes, please explain.

____

____

____

Has your child purposely hurt someone or him/herself? __Yes __No

If yes, please explain.

____

____

____

Has your child experienced any serious emotional losses (such as death of or physical separation from a parent or caretaker)? __Yes __No

If yes, please explain.

____

____

____

Please list any major life transitions or concerns.

____

____

____

Does your family have any current or history of court involvement with DHHS?

If yes, please explain. ____

____

____

Family History

Mothers Name: ____________________ Fathers Name: ______________________________

Occupation: ______________________ ______________________________

Who does your child currently live with?

Name:	Age:	Relationship:	Grade/Job:

Who are you child's significant others NOT living in the same house?

Name:	Age:	Relationship:	Grade/Job:

Describe your child's relationship with their family siblings?

____

____

____

Who is your child closest to?

____

What are some strengths as a family?

____

____

Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets them in trouble? If yes, please explain.

____

____

____

Are there any behaviors that your child fails to do as often as you would like or when you would like?

____

____

____

How do you describe your child's self-esteem?

____

____

____

What goals would you like to accomplish during the therapy process as a parent?

____

____

____

Does your child have different goals they would like to accomplish? (If they are the same, you can skip this one.)

____

____

____

Is there anything else that you think would be important for me to know about your child or your family?

____

____

____

Social History

Does your child have friends? __Yes __No

How many close friends does your child you have? 1 2 3 4 5 or more

List leisure/recreational activities:

____

____

____

List your strengths: ____

List your weaknesses: ____

Developmental History

Was your child exposed to drugs or alcohol before birth or early childhood? If yes, please explain. ____

____

Are there any identified delays in development of:

Speech Functioning __Yes __No

Hearing Functioning __Yes __No

Visual Functioning __Yes __No

Walking __Yes __No

Other Abilities __Yes __No

Has your child had any serious injuries or accidents, specifically involving head injury? If yes, please explain.

____

____

Rater's Name________________________ Child's Name________________________

Relationship to Child ________________ Child's Age________________________

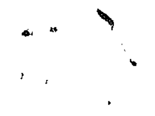
Date of Rating________________________ Child's sex________________________

Therapist Name: ________________

EYBERG CHILD BEHAVIOR INVENTORY

Directions. Below are a series of phrases that describe children's behavior. Please (a) circle the number describing ***how often*** the behavior ***currently*** occurs with your child, and (b) circle either "YES" ***or*** "NO" to indicate whether the behavior is ***currently a problem.***

	How often does this occur with your child?							***Is this a problem for you?***	
	Never		***Seldom***		***Sometimes***	***Often***	***Always***		
1. Dawdles in getting dressed	1	2	3	4	5	6	7	YES	NO
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	YES	NO
3. Has poor table manners	1	2	3	4	5	6	7	YES	NO
4. Refuses to eat food presented	1	2	3	4	5	6	7	YES	NO
5. Refuses to do chores when asked	1	2	3	4	5	6	7	YES	NO
6. Slow in getting ready for bed	1	2	3	4	5	6	7	YES	NO
7. Refuses to go to bed on time	1	2	3	4	5	6	7	YES	NO
8. Does not obey house rules on own	1	2	3	4	5	6	7	YES	NO
9. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	YES	NO
10. Acts defiant when told to do something	1	2	3	4	5	6	7	YES	NO
11. Argues with parents about rules	1	2	3	4	5	6	7	YES	NO
12. Gets angry when doesn't get own way	1	2	3	4	5	6	7	YES	NO
13. Has temper tantrums	1	2	3	4	5	6	7	YES	NO
14. Sasses adults	1	2	3	4	5	6	7	YES	NO
15. Whines	1	2	3	4	5	6	7	YES	NO
16. Cries easily	1	2	3	4	5	6	7	YES	NO
17. Yells or screams	1	2	3	4	5	6	7	YES	NO
18. Hits parents	1	2	3	4	5	6	7	YES	NO
19. Destroys toys and other objects	1	2	3	4	5	6	7	YES	NO



20. Is careless with toys and other objects	1	2	3	4	5	6	7	YES	NO
21. Steals	1	2	3	4	5	6	7	YES	NO
22. Lies	1	2	3	4	5	6	7	YES	NO
23. Teases or provokes other children	1	2	3	4	5	6	7	YES	NO
24. Verbally fights with friends own age	1	2	3	4	5	6	7	YES	NO
25. Physically fights with sisters and brothers	1	2	3	4	5	6	7	YES	NO
26. Constantly seeks attention	1	2	3	4	5	6	7	YES	NO
27. Interrupts	1	2	3	4	5	6	7	YES	NO
28. Is easily distracted	1	2	3	4	5	6	7	YES	NO
29. Has short attention span	1	2	3	4	5	6	7	YES	NO
30. Fails to finish tasks or projects	1	2	3	4	5	6	7	YES	NO
31. Has difficulty entertaining self alone	1	2	3	4	5	6	7	YES	NO
32. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	YES	NO
33. Is overactive or restless	1	2	3	4	5	6	7	YES	NO
34. Wets the bed	1	2	3	4	5	6	7	YES	NO