

ME First Wellness Professional Counselling

Address: 606 33rd Street West

Business: (306) 281-6674

Saskatoon, SK S7L 0W1

Child/Adolescent Intake Form

Name of Child: _____

(Last)

(First)

(Middle Initial)

Date of Birth: _____ Age: ____ Grade: ____

Address: _____ Postal Code: _____

Parents/Caregivers: _____

With whom does the child live? _____

Home phone: _____ Cell phone: _____ Work phone: _____

Messages ok? Yes No

Messages ok? Yes No

Messages ok? Yes No

Emergency contact and phone number : _____

Family Physician: _____ Referred by: _____

Siblings:

Name

Age

What is your primary concern regarding your child?

How long has this been a concern? _____

What help or supports have you already tried for this concern?

What are your goals for counselling regarding your child? _____

What are your child's strengths? _____

What are your child's interests? _____

What are your child's coping mechanisms? _____

**Please circle the letter that best describes your child or your child's situation for each question.
Please feel free to add your own comments after each question if necessary.**

1. How would you best describe your child's diet?
 - a. A lot of fast food and sweets.
 - b. Pretty good most of the time.
 - c. Well balanced and nutritious almost all of the time.
2. How would you best describe your child's sleep habits?
 - a. Does not get enough sleep, always seems tired.
 - b. Gets enough sleep most of the time.
 - c. Always gets enough rest.
3. How would you best describe your child's exercise habits?
 - a. Has vigorous exercise once or twice a week.
 - b. Has some exercise almost every day.
 - c. Engages in vigorous exercise daily.
4. How would you best describe your child's television/video game/computer habits?
 - a. 3 hours or more of TV/video games/computer per day.
 - b. 2 to 3 hours of TV/video games/computer per day.
 - c. 1 hour or less of TV/video games/computer per day.
5. How would you best describe your child's attitude towards learning?
 - a. Complains about learning activities and/or school.
 - b. Enjoys some types of learning and not others.
 - c. Loves to learn and rarely experiences difficulty.
6. How would you best describe the discipline atmosphere in your child's home?
 - a. Discipline is a challenge.
 - b. The child responds to discipline most of the time.
 - c. The child knows the rules of the house and does not break them.
7. How would you best describe the general atmosphere of your home?
 - a. Schedules change frequently (meal times, bedtime, custody schedules, et cetera)
 - b. The basic schedules of the home are pretty consistent.
 - c. The schedules of the home rarely change.

8. How would you describe the emotional atmosphere of your home?
- Loud, in a fun, positive way.
 - Loud, lots of fighting.
 - Moderately quiet; we're not a talkative family.
 - Lots of humor and good feelings.
 - Some of all of the above.
9. How would you describe the incidence of emotional or behavioural problems in your child's extended family (includes problems with alcohol or drug abuse, behavior problems of children or teens, problems at work, mental illness, et cetera)?
10. If your child's parents are divorced, are the parents:
- Recently separated or divorced?
 - Separated or divorced between six months and a year ago?
 - Separated or divorced more than a year ago?
11. If your child's parents are divorced, how would you describe their current relationship?
- Poor. Frequent arguments and disagreements.
 - Average. Most disagreements get settled quickly.
 - Good. Few disagreements. Both parents are very involved in the child's life.
12. How would you best describe your child's physical type?
- Significantly smaller or heavier than other children of the same age.
 - About average compared to children of the same age.
 - Somewhat taller.
13. How would you best describe your child's temperament?
- Difficult and oppositional most of the time.
 - Sometimes easy going, sometimes willful.
 - Very easy going and cooperative.
14. How would you describe your child's general health?
- Frequent health problems and/or identified learning or physical problems.
 - About average. No known physical or learning problems.
 - Exceptionally healthy.
15. How would you describe your child's general language abilities (including reading) and reasoning abilities (including math)?
- Has frequent difficulty. Lags behind other children.
 - About average when compared to children of the same age.
 - Excels in these and other academic areas.
16. How would you describe your child's ability to engage in social relationships?
- Makes friends easily.
 - Has one or two friends.
 - Has no friends/spends most of his/her time alone.
17. Has your child had their hearing tested? Yes No
If yes, are there any hearing problems?
18. Has your child had their sight tested? Yes No
If yes, are there any sight problems?

Indicate which issues your child experiences by making a checkmark beside each that apply:

- | | |
|--|---|
| <input type="checkbox"/> Anxiety /Panic Attacks | <input type="checkbox"/> Avoidance behaviour |
| <input type="checkbox"/> Distracted/forgetful | <input type="checkbox"/> Attraction to dangerous situations |
| <input type="checkbox"/> Complains of Pain (headaches, stomach aches, etc.) | <input type="checkbox"/> Day dreaming |
| <input type="checkbox"/> Startles easily | <input type="checkbox"/> Concentration difficulties |
| <input type="checkbox"/> Accident prone | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Difficulties with organizing, planning | <input type="checkbox"/> Disrupted eating patterns |
| <input type="checkbox"/> Isolated/detached from others | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Digestive problems/stomach aches | <input type="checkbox"/> Tired/tires easily |
| <input type="checkbox"/> Sensitivity to light and/or sounds | <input type="checkbox"/> Difficulty falling or staying asleep |
| <input type="checkbox"/> Recurring dreams or nightmares | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Hyperactivity/restlessness | <input type="checkbox"/> Coordination difficulties |
| <input type="checkbox"/> Emotionally subdued | <input type="checkbox"/> Suicidal ideas |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Feelings of shame and/or guilt | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Exaggerated emotions | <input type="checkbox"/> Repetitive play |
| <input type="checkbox"/> Crying and irritable | <input type="checkbox"/> Diminished curiosity |
| <input type="checkbox"/> Stressed | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Bed wetting and/or soiling | <input type="checkbox"/> Coordination difficulties |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Clingy |
| <input type="checkbox"/> Easily overwhelmed | <input type="checkbox"/> "I can't do it" attitude |
| <input type="checkbox"/> Self-harming behaviors (cutting, scratching, burning) | |
| <input type="checkbox"/> Other (specify) _____ | |

19. Is your child currently being treated for any medical or physical conditions?

Yes No

If yes, identify the condition, and medications, and check below to identify who is involved in the treatment.

Condition _____

Medications: _____.

Involved in treatment:

- | | | |
|---|---|---|
| <input type="checkbox"/> Family Physician | <input type="checkbox"/> Homeopath | <input type="checkbox"/> Massage therapist |
| <input type="checkbox"/> Naturopath | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Physical therapist |
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Occupational therapist | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> other : _____ | | |

History:

Which of the following has your child experienced? Please check all that apply. Please add additional comments below if necessary.

- | | |
|--|--|
| <input type="checkbox"/> Fetal distress | <input type="checkbox"/> Near drowning/suffocation |
| <input type="checkbox"/> Premature birth | <input type="checkbox"/> Birth difficulties |
| <input type="checkbox"/> Fall (stairs/bed/trees/playground equipment/etc.) | <input type="checkbox"/> Auto/bike accidents |

- Broken bones
- Major injuries or burns
- Prolonged immobilization (casts, braces, etc.)
- Surgery
- Life threatening or severe illness
- Poisoning
- Medical procedures (ie. stitches)
- Lost
- Other _____

- Divorce/separation
- Death of significant individual or pet
- Witness to violence
- Abuse (verbal, physical, sexual)
- Loss of possessions (fire, flood, robbery, etc.)
- Dental procedures
- Bullying (school, neighbourhood, sibling)
- Exposure to extremes in temperature

Additional Information:

A copy of the current custody order has been provided: Yes No N/A

I understand that the treatment given is not a substitute for medical or psychological diagnosis. The practitioner does not diagnose conditions, nor prescribe or perform medical treatment.

Signature of Caregiver: _____ Date: _____

Witness Signature: _____