MidAmerica Family Treatment Center, LLC
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Family Intake

Child's Name_____ Male___ Female___ Race_____ Language_____

Child's DOB _____ Adopted _____ Foster Care _____ Birth _____ Relative_____

Does the child have an email they use?_____

Custodial Parent Name_____ DOB_____ Email _____

Home Address_____ City_____ State_____

Zip Code _____ Home Phone _____ Cell Phone _____ Best contact_____

Can we leave text messages Yes___ No___ Voice Messages Yes___ No___

Custodial Parent Name_____ DOB_____ Email _____

Home Address_____ City_____ State_____

Zip Code _____ Home Phone _____ Cell Phone _____ Best contact_____

Can we leave text messages Yes___ No___ Voice Messages Yes___ No___ Email address_____

If adopted: Domestic_____ International _____ At what age_____

At the time of adoption, where was the child?_____

If the child was adopted internationally, Country?_____ Orphanage ____ Foster care ____ other____

DCN or insurance provider_____ ID #_____ Co-pay _____

Subsidy: Yes ____ No____ If this child is in foster care, what is the permanency plan?_____

Referring Case Manager Agency_____ GAL or CASA? _____

Childhood History

If this child was in foster care or with a relative, how many moves from the birth family has this child made?

Please indicate where this child has been, for how long?

If there is not enough space, please feel free to use the back of this form for that information. It is very important to know where this child has come from if that information is available to you).

Who lives in the home? (Please include foster/adopt/birth of other children in home as well)

What do you like most about your child?

What is your child's greatest strength?

What does your child struggle with the most?

Has your child ever made statements of wanting to seriously hurt him/herself or someone else? Yes No

Has he/she ever purposely hurt him/herself or someone else? Yes No

Any recent or current stressors in the child's life?

Does your child have special care needs/issues in daily living skills?

Please indicate if there are special issues or situations that may need to be considered for this child____

Please check all behaviors that apply to your child.

- ____ Superficially engaging and charming
- ____ Very clingy, needy
- ____ Lack of appropriate contact
- ____ Poor cause and effect thinking
- ____ Abnormal eating habits
- ____ Learning lags
- ____ Urinating in inappropriate places
- ____ Spreading feces on walls or floors
- ____ Preoccupied with blood or violence
- ____ Has threatened siblings/parents
- ____ Has made suicidal threats or actions
- ____ Does not like to be touched
- ____ Emotionally immature
- ____ Affectionate with total strangers
- ____ Poor peer relationships
- ____ Lying
- ____ Hoarding food or things
- ____ Bowel movements in pants
- ____ May hurt other without remorse
- ____ Preoccupied with fire
- ____ Abused animals in some way
- ____ Stealing

Add any additional information here:

_____

_____

_____

Please provide the following Information about your child and family:

Tell me about the child's family of origin. If in foster care or adopted:

_____

_____

What services is your child currently receiving?

Therapy (i.e. CBT, PCIT, Attachment) ____ OT ____ PT ____ Vision ____ Other____

Does anyone in the family of origin currently use, or has used in the past, any type of drug, tobacco, or alcohol? Yes ____ No____ If yes, please describe:_____

Has anyone in the family of origin been treated for a mental health issue such as depression, bi-polar (manic depression), schizophrenia, etc.? Yes ____ No____

Education History

What school does your child attend?_____ Phone number_____

School address_____ City_____ State_____ Zip_____

What grade is he/she in? _____ Teacher's name (or contact person)_____

Does this child have an IEP or a 504? Yes _____ No_____

Has your child experienced any of the following problems at school?

____Fighting ____Lack of friends ____Drugs/alcohol ____Detention

____Suspension ____Learning disabilities ____Poor attendance ____Poor grades

____Gang influence ____Incomplete homework ____Behavior problems

Does your child excel in school and get along very well with teachers but does not have very good social skills with peers? Yes _____ No_____

Medical History

Child's Doctor_____

Address_____

Phone number_____

Last medical exam?_____

Did the child's mother use tobacco, drugs, alcohol, or medications during pregnancy? Yes____ No____
If yes, please describe:

_____

_____

Has your child experienced any of the following medical problems?

___Head injury ___Surgery ___Seizures/convulsions ___Asthma

___High fever ___Hearing problems ___Vision problems ___Allergies

Please list any current medical problems of physical handicaps:

_____

Is your child under the care of a psychiatrist or someone who prescribes psychotropic medication?

Yes ____ No____

Name of the prescribing physician or psychiatrist_____

Fax number _____Phone number _____Address_____

City_____State_____Zip_____

Do we have permission to communicate with your child's primary physician and psychiatrist for continuity of care? Yes _____No_____

Current Medication	Dosage	Frequency	Prescribing Dr.	Reason	Compliance

Add any additional information regarding medications or important medical information here.

_____

_____

_____

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