

*Rigby Psychological Services, PLLC*  
2505 South 17<sup>th</sup> St, Suite 200  
Wilmington, NC 28401  
(910) 254-4545

Dear Parent(s)/Guardian(s):

I am excited to be working with you and your child soon. Enclosed are several forms that need to be completed *prior* to your child's initial appointment.

The following forms are included within this packet:

1. Background History Form
2. Billing/Insurance Paperwork

Please **complete and return** these forms to the following address *as soon as possible*:

Attention: Intake  
Potentials  
2505 S. 17<sup>th</sup> St, Suite 200  
Wilmington, NC 28401

If any questions or concerns arise as you complete these forms, please to call my office staff at **910-254-4545**.

I look forward to seeing you soon!

# Intake Packet for Child/Adolescent Therapy Clients

## Background Information Form

The purpose of this questionnaire is to gather information about your child and family before your child's intake appointment. Along with the intake appointment itself, your answers to this form will assist your child's therapist in planning therapy to address your child's (and family's) specific needs. Do not worry if you do not have all the information to answer every question, as we will be discussing this further at your child's intake appointment. Your time and effort in completing this background form is greatly appreciated!

### General Information

Date: \_\_\_\_\_ Form Completed By: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Child's Name: \_\_\_\_\_

(First)

(Middle)

(Last)

("Nick Name")

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of School: \_\_\_\_\_ School District: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Best Phone # to reach \_\_\_\_\_ Best Phone # to reach \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

Highest Grade Completed \_\_\_\_\_ Highest Grade Completed \_\_\_\_\_

Best email address to contact you \_\_\_\_\_.

Does your child have other parent(s)/stepparent(s)/primary caregivers?  Yes  No

If yes, please provide the following information:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship to this child: \_\_\_\_\_ Relationship to this child: \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

Highest Grade Completed \_\_\_\_\_ Highest Grade Completed \_\_\_\_\_

Is your child adopted?  Yes  No

With what adult(s) does this child live? \_\_\_\_\_

At what age did the child come into the current living situation? \_\_\_\_\_

Child's Name \_\_\_\_\_

Child's DOB \_\_\_\_\_

Please list ALL brothers and sisters, AND any other children living in the home with the client.

Age	Sex	Relationship to this Child	Living at home?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Pregnancy and Birth History**

Did any complications occur during delivery?  Yes  No

If yes, please explain:

Birth weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz What was the baby's condition following delivery?

Please describe any specialized treatment provided to baby following delivery: \_\_\_\_\_

What was the mother's condition following delivery? \_\_\_\_\_

Length of hospital stay following delivery: \_\_\_\_\_ Mother \_\_\_\_\_ Baby

Any concerns during the newborn period (e.g., colic, excessive crying, feeding difficulty)?  Yes  No

If yes, please state: \_\_\_\_\_

**Health and Medical History**

Who is your child's primary care physician? \_\_\_\_\_

Had a medical check-up within the last 12 months?

Has your child had any chronic or serious health problems?  Yes  No If so, please state \_\_\_\_\_

If yes, what surgeries or procedures and why? \_\_\_\_\_

What medications is your child currently taking? \_\_\_\_\_

\_\_\_\_\_

Has your child ever been given a diagnosis (e.g., anxiety, ADHD)? If so, please state diagnosis or diagnoses:

**Developmental History**

Was your child delayed in meeting any major developmental milestones?  Yes  No If yes, state which milestone(s) were delayed and note whether your child was just a little slower than typical or if there was a significant delay: \_\_\_\_\_

**School History**

What schools have your child attended? (please list in chronological order beginning with nursery/preschool)

What are your child’s academic strengths? \_\_\_\_\_

In what areas does your child have more difficulty? \_\_\_\_\_

Are you worried when you compare your child to other child his/her age academically?  Yes  No

If yes, please describe \_\_\_\_\_

Does your child like to attend school?  Yes  No

Has your child ever repeated a grade?  Yes  No Which? \_\_\_\_\_ Reason? \_\_\_\_\_

Does your child receive extra school help?  Yes  No If yes, explain:

Has/did your child ever receive special education services?  Yes  No

If yes, why were these services initiated (e.g., speech, reading difficulty)? \_\_\_\_\_

If services have been discontinued, when and why did this occur? \_\_\_\_\_

**Social and Behavioral History**

Are you worried when you compare your child socially to other children his/her age?  Yes  No

If yes, please describe \_\_\_\_\_

How easily does your child make friends?  Worse than average  Average  Better than average

Who does your child get along with best?  Older children  Same-age children  Younger children

How many *close* friends does your child have? \_\_\_\_\_

Does your child have a best friend?  Yes  No

If yes, how old is he/she? \_\_\_\_\_ How long have they been friends? \_\_\_\_\_

What are your child’s main hobbies or interests? \_\_\_\_\_

Please list the things your child does well: \_\_\_\_\_

What are the most positive features about your child? \_\_\_\_\_

Are there behavior problems at school?  Yes  No

If yes, please describe \_\_\_\_\_  
 \_\_\_\_\_

Are there behavior problems at home?  Yes  No

If yes, please describe \_\_\_\_\_  
 \_\_\_\_\_

Has your child been in therapy/counseling before?  Yes  No

How positive of an experience was it for your child/family? \_\_\_\_\_  
 \_\_\_\_\_

**Family Functioning & History**

Biological mother's age and general health: \_\_\_\_\_

Biological father's age and general health: \_\_\_\_\_

Any significant changes in the home in the past couple of years?

How well does your child relate to (get along with) other members of the family?

Please check box to indicate if any of the child's *biological* family members have had the following conditions.

**Note:** G.Fa= Grandfather, G. Mo= Grandmother, and A/U/C= Aunts, Uncles, or *first* cousins

Condition	Immediate Family			Father's Relatives			Mother's Relatives		
	Dad	Mom	Sib	G. Fa	G. Mo	A/U/C	G. Fa	G. Mo	A/U/C
Held back in school									
Mental Retardation									
Learning Disabilities									
Language/Speech Delay									
Hyperactivity									
Attention Deficit									
Conduct Problems									
Drug/Alcohol Abuse									
Tics									
Depression									
Anxiety									
Panic Attacks									
Obsessive-Compulsive Disorder									

Child's Name \_\_\_\_\_

Child's DOB \_\_\_\_\_

Hearing Loss									
Vision Problems									
Other: _____									

**Reason(s) for Current Appointment**

Who recommended or referred your child for this appointment? \_\_\_\_\_

What questions or concerns would you like addressed/answered? \_\_\_\_\_

---



---



---



---

What do you feel led to/caused these concerns? \_\_\_\_\_

---



---



---

When did you first notice these concerns? \_\_\_\_\_

**Additional Comments** (If needed, please use the backside of this page.)

---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---

