***Courtney James, MSW, LCSW***
***2505 South 17th 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. Consent for Services (Includes Billing/Insurance Paperwork)

Please **complete and return** these forms to the following address ***as soon as possible*** by email to cjames.msw.lcsw@gmail.com, fax to 910-254-4557, or mail to:

*Potentials*
*Attn: Courtney James*
*2505 S. 17th St, Suite 200 Wilmington,*
*NC 28401*

If you are unable to send the intake packet prior to your Initial Interview/Intake Session; please ensure that you bring this document and Consent for Services completed to you first session.

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

Courtney James, MSW, LCSW

Child's name _____ Child's DOB _____

# 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: _____

Date of Birth: _____ Sex: _____ Grade:_____

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 child:_____ Relationship to child:_____

Occupation_____ Occupation:_____

Highest Grade Completed:_____ Highest Grade Completed:_____

Is your child adopted? □ Yes □ No

With what adult(s) does this child live? _____

Child's name _____ Child's DOB _____

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

*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' 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? _____

What are the most positive features about your child? _____

Please list the things your child does well: _____

Are there behavior problems at school? □ Yes □ No

Are there behavior problems at home? □ Yes □ No

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

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

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**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

| | Immediate Family | | | Father's Relatives | | | Mother's Relatives | | |
|---|---|---|---|---|---|---|---|---|---|
| **Condition** | **Dad** | **Mom** | **Sib** | **G. Fa** | **G. Mo** | **A/U/C** | **G. Fa** | **G. Mo** | **A/U/C** |
| Held back in school | | | | | | | | | |
| Mental Retardation | | | | | | | | | |

Child's name _____ Child's DOB _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Learning Disabilities | | | | | | | | | |
| Language/Speech Delay | | | | | | | | | |
| Hyperactivity | | | | | | | | | |
| Attention Deficit | | | | | | | | | |
| Conduct Problems | | | | | | | | | |
| Drug/Alcohol Abuse | | | | | | | | | |
| Tics | | | | | | | | | |
| Depression | | | | | | | | | |
| Anxiety | | | | | | | | | |
| Panic Attacks | | | | | | | | | |
| Obsessive-Compulsive Disorder | | | | | | | | | |
| 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? _____

Child's name _____ Child's DOB _____

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

Child's name _____ Child's DOB _____