Shelley Chambers, 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. Billing/Insurance Paperwork

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

Attention: Intake
Potentials
2505 S. 17th 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!

Shelley E. Chambers, LCSW

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? _______________________________________

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? ____

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

	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									
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? ____

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

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Child's Name _________________________ *Child's DOB* ____________________________