

Whitney Philemon, 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 whitney.philemon@gmail.com, fax to 910-254-4557, or mail to:

Potentials
Attn: Whitney Philemon
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!

Whitney Philemon, MSW, LCSW

Child's Name _____

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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: _____

(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' 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

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.)
