the mindful maple
CHILD COUNSELLING AND SUPPORT SERVICES

INTAKE FORM – PARENT

Please complete the following form with all requested information and return it **before your initial intake meeting**. If there are any questions that you do not wish to answer, please leave them blank.

CLIENT INFORMATION: PARENT/CHILD

Parent FULL NAME (or Legal Guardian) 1: _____

Relationship to Child: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other

Has sole legal custody of child? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

IF A FORMAL CUSTODY AGREEMENT OR ORDER EXISTS, A COPY WILL BE REQUIRED FOR YOUR CHILD'S FILE.

Address: _____

Preferred contact number: (_____) _____ - _____ (Circle) Home / Work / Cell

Consent to contact by phone? Y N

Consent to leave a message? Y N

Email: _____ Consent to email? Y N

Parent FULL NAME (or Legal Guardian) 2: _____

Relationship to Child: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other

Has sole legal custody of child? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Address (if different from above): _____

Preferred contact number: (_____) _____ - _____ (Circle) Home / Work / Cell

Consent to contact by phone? Y N

Consent to leave a message? Y N

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Email: _____ Consent to email? Y N

Child's FULL NAME: _____ Gender: _____

Age: _____ Date of Birth (mm/dd/yyyy): ____/____/____

Primary residence or living arrangement: _____

Relation to Parent/Caregiver: ☐ Biological ☐ Step - ☐ Adopted ☐ Other

SIBLINGS (oldest to youngest): Continue onto back of paper if needed

Sibling #1: Name: _____ Age: _____ Gender: _____

(Circle) Relation: Biological / Step - / Other Primary Residence: Home / Away

Sibling #2: Name: _____ Age: _____ Gender: _____

(Circle) Relation: Biological / Step - / Other Primary Residence: Home / Away

Sibling #3 Name: _____ Age: _____ Gender: _____

(Circle) Relation: Biological / Step - / Other Primary Residence: Home / Away

Sibling #4 Name: _____ Age: _____ Gender: _____

(Circle) Relation: Biological / Step - / Other Primary Residence: Home / Away

Additional Siblings (name, age, gender, relation): _____

Do any of your other children have special concerns or issues? _____

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IMMEDIATE CONCERNS

Who recommended that your child seek counselling? _____

Presenting concerns at Home: _____

_____

_____

_____

When did these problems begin? _____

Presenting concerns at School: _____

_____

_____

When did these problems begin? _____

Presenting concerns in the Community: _____

_____

_____

When did these problems begin? _____

Have there been any significant changes in the home or in your child's life over the last two years? _____

_____

_____

_____

In the last 2 weeks, how intense is your child's emotional distress? (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

How much do these problems affect your child's ability to perform daily tasks? (Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)

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Please indicate any of the following areas of concern, past or present:

☐ Anger Management	☐ Poor Concentration	☐ Self-injurious Behavior
☐ Anxiety/Excessive Worry	☐ Suicidal Ideation	☐ Body Image
☐ Depressed Mood/Sadness	☐ Impulsivity	☐ Bullying/Teasing
☐ Irritability	☐ Family Problems	☐ Nightmares
☐ School Problems	☐ Low Self-Esteem	☐ Abuse/Neglect
☐ School Refusal	☐ Lying	☐ Hyperactivity
☐ Opposition/Defiance	☐ Social/Relationship	☐ Medical/Physical
☐ Distractibility	☐ Sleeping Problems	☐ Other

Has your child ever attended counselling?

Where: _____

When: _____

Duration: _____

Mental health concern at the time: _____

Outcome: _____

Has you child had previous testing or psychological examinations?

Type: _____ When: _____

Outcome: _____

EDUCATIONAL HISTORY

Current school: _____ Grade: _____

Previous school(s): _____

Has your child ever required an aid or tutor? _____

Has your child ever repeated a grade? _____

Has your child ever had a Psychoeducational Assessment? _____

What is your child's average grade: _____

Areas of academic strength? _____

Areas of academic weakness? _____

FAMILY AND HOME

What are your child's interests (sports, hobbies, talents, etc.)? _____

How does your child spend his/her free time at home? _____

Current habits:

☐ Video games ☐ Gross motor activities (e.g., exercise)

☐ Mobile device ☐ Smoking/Alcohol/Drug use

☐ Caffeine intake ☐ Chores and responsibilities

☐ Outdoor activities ☐ Other:

Describe any habits that occur in excess: _____

Is there any family conflict in the home? _____

Describe your child's relationships with each of the following persons (if applicable):

Biological Mother: _____

Biological Father: _____

Legal guardian(s): _____

Step-parent(s): _____

Extended family: _____

Other: _____

SOCIALIZATION

Does your child find it easy/difficult to make friends? _____

Has your child ever been bullied? _____

Has your child ever bullied another child? _____

Does your child play primarily with children his/her own age? Younger? Older? _____

Does your child have a best friend? Group of friends? _____

Does your child have any problems with his/her peers (including past experiences): _____

What are your child's strengths? _____

What are your child's weaknesses? _____

What qualities have helped your child overcome past difficulties? _____

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MEDICAL HISTORY

Is your child diagnosed with a *psychiatric* ailment? _____

Is your child diagnosed with a *physiological* ailment? _____

Is your child currently taking prescribed medication?

What: _____

Duration: _____

Quantity: _____

Reason for prescription: _____

Does your child have any concerns with the following:

☐ Allergies ☐ Sleep ☐ Dizziness

☐ Hearing ☐ Fatigue ☐ Other

☐ Vision ☐ Appetite

☐ Speech ☐ Stomachaches

OTHER

What are your goals for your child in counselling? _____

Any concerns about your child attending counselling? _____

Additional concerns and/or questions: _____