CHESAPEAKE LIFE CENTER
COUNSELING INTAKE FORM – FAMILY

Office use only

CLC Client Id#: ___________________
Office: ☐AA ☐PG ☐Other ___________
Source: ☐HOC ☐Community ☐________

PARENT / GUARDIAN'S PERSONAL INFORMATION

First Name: ______________________ Middle Initial: ________ Last Name: ______________________

Address: _________________________ City: _______________ State: ________ Zip: ____________

Home Phone: ______________ Work Phone: ________________ Cell Phone: ___________________

Email Address: ____

CHILD'S PERSONAL INFORMATION *(List additional children receiving services on back)*

First Name: ______________________ Middle Initial: ________ Last Name: ______________________

Age: _____ Birth date: ________ School: ________________ Grade: ____ Gender: ☐Male ☐Female

Who referred you / How did you hear about us: ____

COUNSELING HISTORY

Has the child received counseling before: ☐Yes ☐No

If yes, for what: ____

Who counseled/treated the child: _____________________ When:__________ Was it helpful: ☐Yes ☐No

Have any family members ever had counseling?: ☐Yes ☐No

If so, for what: ___________________ How long: _____________________ Was it helpful: ☐Yes ☐No

Is there any family history of drug/alcohol abuse?: ☐Yes ☐No

If so, who: ____ Treatment was received: ☐Yes ☐No

Is there any family history of sexual or physical abuse?: ☐Yes ☐No

If so, who?: ____ Treated: ☐Yes ☐No

CHILD'S MEDICAL HISTORY

Pediatrician: ____________________________________ Phone: ____________________________________

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Date of child's last physical: ______________________

Does the child have any medical problems that require treatment at this time: ☐ Yes ☐ No

Please describe:____

Is the child currently taking any prescription drugs: ☐ Yes ☐ No

Name: ____________________ Dosage: ____________________ Purpose:____________________

Name: ____________________ Dosage: ____________________ Purpose:____________________

Name: ____________________ Dosage: ____________________ Purpose:____________________

Is the child currently taking any non-prescription drugs: ☐ Yes ☐ No

Name: ____________________ Dosage: ____________________ Purpose:____________________

Name: ____________________ Dosage: ____________________ Purpose:____________________

Continued on other side

CHILD'S MEDICAL HISTORY (continued)

Has the child ever been hospitalized?: ☐ Yes ☐ No

Please describe: ______________________ Date(s): ____________

Please describe: ______________________ Date(s): ____________

Please describe: ______________________ Date(s): ____________

Please describe: ______________________ Date(s): ____________

CHILD'S LOSS HISTORY

For whom or what is the child grieving: ______________________

Relationship: ____________ Date of Loss: ________

The circumstances leading to the death or separation: ______________________

Did the child have the opportunity to say goodbye: ☐Yes ☐No ☐Uncertain

Describe the child's relationship prior to the death: ☐Loving ☐Distant ☐Mixed Feelings ☐Other: ____________

____

CHILD'S CURRENT FUNCTIONING

I have observed the following changes in my child since the death or event occurred:

Appetite: ☐Less than usual ☐No change ☐More than usual ☐Uncertain

Sleep Patterns: ☐Sleeping less than usual ☐No change ☐Sleeping more than usual every day ☐Uncertain

Feeling sad or empty: ☐Never ☐Occasionally ☐Frequently ☐Nearly every day ☐Constantly

Having trouble focusing on schoolwork: ☐Never ☐Occasionally ☐Frequently ☐Nearly every day ☐Constantly

Diminished ability to think or concentrate or indecisiveness nearly every day: ☐Yes ☐No ☐Uncertain

Talks of joining the departed/harming self: ☐Never ☐Occasionally ☐Frequently ☐Nearly every day ☐Constantly

Behavioral difficulties at school or home: ☐Never ☐Occasionally ☐Frequently ☐Nearly every day

List additional children receiving counseling

CHILD'S PERSONAL INFORMATION — Child #2

First Name: ____________ Middle Initial: ______ Last Name: ____________

Age: _____ Birth date: ______ School: ____________ Grade: _____ Gender: ☐Male ☐Female

CHILD'S PERSONAL INFORMATION — Child #3

First Name: ____________ Middle Initial: ______ Last Name: ____________

Age: _____ Birth date: ______ School: ____________ Grade: _____ Gender: ☐Male ☐Female

CHILD'S PERSONAL INFORMATION — Child #4

First Name: ____________ Middle Initial: ______ Last Name: ____________

Age: _____ Birth date: ______ School: ____________ Grade: _____ Gender: ☐Male ☐Female