

**Willamette Valley Family Center, LLC**

610 Jefferson Street - Oregon City, Oregon 97045 ---- (503) 657-7235

**CHILD INTAKE EVALUATION - (To be completed by parents)**

**1. IDENTIFYING INFORMATION**

Child's Name: _____	Today's Date: _____	Referred By: _____
---------------------	---------------------	--------------------

Gender: M  F  Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security (ID) #: \_\_\_\_\_  
mm/dd/yyyy

Custodial Parent Name: \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Home address: \_\_\_\_\_  
Street City State Zip

Telephone: \_\_\_\_\_  
(home) mother (work) father (work)

May we leave messages for your at home? Yes  No  May we leave messages for your at work? Yes  No

School Child Attends: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Phone: \_\_\_\_\_

Others living in the home: \_\_\_\_\_  
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

\_\_\_\_\_  
(name, birthdate, relationship to client) (name, birthdate, relationship to client) (name, birthdate, relationship to client)

Immediate family living outside the home: \_\_\_\_\_  
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

Name of insured: \_\_\_\_\_ Insured date of birth: \_\_\_\_\_  
mm/dd/yyyy

Address of insured person: \_\_\_\_\_  
Street City State Zip

Relationship of client to insured person: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
Street City State Zip

Insurance Identification Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employer of insured person: \_\_\_\_\_

Secondary insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of secondary insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
mm/dd/yyyy

Secondary company address: \_\_\_\_\_  
Street City State Zip

Secondary identification number: \_\_\_\_\_ Group number: \_\_\_\_\_

Employer on secondary insurance: \_\_\_\_\_

PATIENT OR AUTHORIZED PERON'S SIGNATURE: I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment to provide of services

Child's Name: \_\_\_\_\_

**2. PRESENTING PROBLEM**

Describe the child's problem (s) that brought you here today:

**Check any of the symptoms that the child has been having:**

Depressed mood		Feels hopeless	
Extreme sadness		Tearful/crying spells	
Trouble concentrating		Memory problems	
Change in sleeping habits		Lack of energy	
Security blanket or object		Stuttering	
Bedwetting		Thumb sucking	
Change in eating habits		Weight/appetite changes	
Problems getting along with family		Problems getting along with friends	
Doesn't seem to enjoy usual activities		Feeling of extreme happiness	
Trouble doing school work		Truancy	
Feeling stressed		Irritability	
Low self-esteem		Isolation/withdrawal	
Perfectionistic		Expressed feeling of guilt	
Worries		Seems nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Tense/uptight	
Anger outbursts		Acting violently	
Running away		Harm to animals	
Has hurt or cut on themselves		Fire setting	
Thoughts of killing self		Thoughts of killing others	

**3. WHAT HAS BEEN DONE ABOUT THIS PROBLEM SO FAR?**

**Have you worked with the child's teacher or school counselor?** Yes  No

If you have, please describe it below

Name of teacher or counselor:	Date (s):

**Has this child been in counseling before?** Yes  No

If the child has been in counseling before, please describe it below, starting with the most recent first.

A. When was the counseling?	Date (s):
Who did you see?	Name:
Explain what happened:	
B. When was the counseling?	Date (s):
Who did you see?	Name:
Explain what happened:	

**Has the child been prescribed any psychiatric medications?** Yes  No

If yes, please describe:	Date (s):

**4. SUSTANCE USE HISTORY (If Applicable)**

Does the child use tobacco (any form?)	Current <input type="checkbox"/>	Suspected <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Does the child use alcohol?	Current <input type="checkbox"/>	Suspected <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Does the child use caffeine (any form including cola drinks)?	Current <input type="checkbox"/>	Suspected <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Does the child use recreational drugs?	Current <input type="checkbox"/>	Suspected <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>

Child's Name: \_\_\_\_\_

**5. MEDICAL INFORMATION**

Has the child seen a doctor within the last year?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
What was that for?		
Who is the child's doctor?	Phone:	
Is the child taking any medications (prescription or over-the-counter)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please list any medications that the child is taking:		
Please list any major medical problems that the child has had such a chronic illness, serious illness, operations, injuries or trauma to the head, etc.:		
Does the child have allergies to anything?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Describe any allergy problems that he or she may have:		
Does the child have problems with sleeping?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the child have any problems with eating?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the child have any problems with toileting ?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Describe the problem(s):		
Has the child been affected by any issues such as witnessing violence, having accidents, experiencing loss or experiencing abuse (physical, sexual or emotional). Please describe the relevant issue(s):	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Continue on other side

## 6. DEVELOPMENTAL HISTORY

Were there any problems with the pregnancy or the delivery of the child?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any problems with eating, sleeping or crying spells, colic, nightmares, etc.?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Did the child demonstrate any difficulties or delays in walking, talking, and toilet training?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has there been any family crisis such as marital separation or divorce?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have there been any mental health problems in the family of origin?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have there been any substance use or abuse issues in the family?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Briefly describe the child's relationship to parents:		
Briefly describe the child's relationship to siblings:		
Briefly describe the child's temperament:		

## 7. SCHOOL HISTORY

When did the child start school?
Were there any problems when the child started school? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>
What problems have come up during the school years?
What grades is the child getting?
Describe any changes in the child's school performance:
How does the child get along with his or her teachers?
How does the child get along with his or her friends or peers in school?
What are the child's favorite subjects or school activities?
What subjects or activities does the child have problems with?