Beth Hollander, Ph.D.
358 Veterans Memorial Highway, Suite 10
Commack, NY 11725
(516) 336-8149

Child Intake Form

Available on my website at www.drbethhollander.com, in the Forms section

HISTORY OF THE PROBLEM

When did your child first start experiencing the problem(s) that brought you to the clinic today?
____
____
How often does the problem occur? ____
How long does it last? ____

Does your child have any thoughts of harming him/herself? No Yes
Has your child ever attempted to harm him/herself? No Yes
If yes, please explain: ____
____
Does your child have any thoughts of harming someone else? No Yes
Has your child ever attempted to harm someone else? No Yes
If yes, please explain: ____
____

Has your child ever had previous therapy/counseling of any kind? No Yes
If yes, when and for how long? ____
What concerns were addressed in therapy? ____________________________________
____
____
Was this experience helpful (please explain)? __________________________________
____

Has your child ever been hospitalized for emotional/behavioral problems? No Yes
If yes, when/where was this: ____
____

Has your child been prescribed medications to control emotional/behavioral problems?
No Yes
If yes, please list medications, when prescribed, and by whom: ___________________
____
____

To your knowledge, has your child experimented with alcohol/drugs? No Yes
Are you concerned that your child might have or be developing a problem with alcohol or drugs?

No Yes

If yes, please explain: ____
____

FAMILY

Has this child ever experienced any parental separations, divorces, or death? No Yes
If yes, when? ____________________________ How old was the child at the time? ________
Please describe the circumstances. ____
____

If parents are separated or divorced, who has custody of this child? _______________________
How often does the other parent see this child?

____ Weekly or more often ____ Once or twice a month
____ Few times a year ____ Never

Please list the age and sex for each sibling (including those deceased, and step-siblings):

Age Sex Relationship to Child Living at home?
____ No Yes
____ No Yes
____ No Yes
____ No Yes
____ No Yes
____ No Yes

Other than any children already indicated above and parents, who else lives in the child's household? ____
____

Has anyone in the child's family had treatment for emotional problems? No Yes
If yes, please briefly explain (who/when): ____
Has anyone in your family ever attempted or committed suicide? No Yes
If yes, please briefly explain (who/when): ____

FAMILY HEALTH
Describe father's present health: ____
Describe mother's present health: ____

Indicate any significant family medical history, including family member's relationship to the child. ____
____
____
____

What kinds of stressful events has your child experienced recently?
____
____
____

What kinds of stressful events have family members experienced recently?
____
____
____

CHILD'S EDUCATION
School ____
Grade _______

Describe any difficulties or problems your child is having in school:
____
____
____

CHILD'S DEVELOPMENT
Pregnancy and delivery
Was this a planned pregnancy? No Yes
Was the mother under a doctor's care? No Yes
Number of previous pregnancies/miscarriages: ______
Describe any complications that occurred during the pregnancy: _________________________
____
What drugs/medications were used during the pregnancy? ______________________________
____
At this child's birth, what was the mother's age? __________ Father's age? __________
Length of pregnancy: ___________ weeks Birth weight: ____ lbs ____ oz.

Child's condition at birth:

____

Mother's condition at birth:

____

Length of stay in hospital: Mother _____ days Child _____ days

Is this child adopted? No Yes

If yes, please provide adoption history: _______________________________________

____

____

____

At what age was this child toilet trained? Days: __________ Nights: __________

Did bed-wetting occur after toilet training? No Yes

If yes, until what age: ___________

Did soiling occur after toilet training? No Yes

If yes, until what age: ___________

Describe sleep patterns or problems:

____

____

Language difficulties? No Yes

If yes, describe: ____

____

Delays with child's walking? No Yes

If yes, describe: ____

____

As a young child, did your child have problems getting along with others? No Yes

If yes, describe: ____

____

Were there other problems experienced during the child's first year? No Yes

If yes, describe: ____

____

CHILD'S MEDICAL CARE

Child's physician: ___________________________ Telephone: ________________________
Address:
____
How often does this child see a doctor? _________________
Date of last visit: ____________________

Is this child currently on any medication? No Yes
If yes, indicate type and reason: ____
____
____

Does your child have any history of the following (please circle all that apply):
hospitalizations surgeries high fevers serious accidents
eye, ear, nose & throat problems digestive disorder head injuries seizures
loss of consciousness serious illness allergies

Please list below details of any conditions you circled above, including any additional childhood illnesses and other medical conditions:

Condition/hospitalization Age Treated by whom? Outcome of treatment
____
____
____
____

CHILD'S INTERESTS AND ACTIVITIES
Is this child involved in any extracurricular activities, such as school sports or music programs, clubs, or religious organizations? No Yes
If yes, please describe: ____
____
____

Please describe your child's strengths and positive characteristics: ________________________
____
____
____
____

Other information you feel is important and wasn't asked about:

____
____
____
____
____