Pediatric Counseling Center

375 Collins Road NE, Suite 17 Cedar Rapids, Iowa 52402
Angela Cantrell Fielding Counseling, LLC **Dr. Sandra K. Fischer Counseling, PLLC**
319-208-0175 **319-409-6899**

CHILD/ADOLESCENT INTAKE FORM

Child Information:

Name of Child:_____ DOB:_____ Child lives with:_____
School:_____ Grade:_____ Teacher: _____
Identified Ethnicity:_____ Pediatrician:_____

Parent/Legal Guardian Contact Information

Mother's Name: _____ DOB: _____
Address (City, State and Zip):_____
Preferred Phone:_____ ☐Cell ☐ Home ☐ Work Ok to leave a message? ☐Yes ☐ No Text? ☐Yes ☐No
Secondary Phone:_____ ☐Cell ☐ Home ☐ Work Ok to leave a message? ☐Yes ☐ No Text? ☐Yes ☐No
Email address:_____ Is it ok to email? ☐ Yes ☐ No

Father's Name: _____ DOB: _____
Address (City, State and Zip):_____
Preferred Phone:_____ ☐Cell ☐ Home ☐ Work Ok to leave a message? ☐Yes ☐ No Text? ☐Yes ☐No
Secondary Phone:_____ ☐Cell ☐ Home ☐ Work Ok to leave a message? ☐Yes ☐ No Text? ☐Yes ☐No
Email address:_____ Is it ok to email? ☐ Yes ☐ No

If married, how long have you been married?_____ If divorced, how long have you been separated?_____
If divorced, who has physical custody? _____ Is it full or joint? _____
Who has legal custody? _____ Is it full or joint? _____
A Copy of the Divorce Decree may be requested. If parents are divorced, describe custody arrangements:
_____
_____

Family Dynamics

Siblings (biological, half-siblings, step-siblings)

Name	DOB	School	Relationship

Step-Parent(s)/Guardian(s):_____ DOB: _____
Address (City, State and Zip):_____
Preferred Phone:_____ ☐Cell ☐ Home ☐ Work Ok to leave a message? ☐Yes ☐ No Text? ☐Yes ☐No
Secondary Phone:_____ ☐Cell ☐ Home ☐ Work Ok to leave a message? ☐Yes ☐ No Text? ☐Yes ☐No
Email address:_____ Is it ok to email? ☐ Yes ☐ No

Step-Parent(s)/Guardian(s):_____ DOB: _____
Address (City, State and Zip):_____
Preferred Phone:_____ ☐Cell ☐ Home ☐ Work Ok to leave a message? ☐Yes ☐ No Text? ☐Yes ☐No
Secondary Phone:_____ ☐Cell ☐ Home ☐ Work Ok to leave a message? ☐Yes ☐ No Text? ☐Yes ☐No
Email address:_____ Is it ok to email? ☐ Yes ☐ No

Primary Caregiver & Contact Information (Complete only if Biological Parent is not the Primary Caregiver)

Foster Parent/Kinship Caregiver(s): _____ Relationship to Child_____
Address: _____
Marital Status: _____ Phone: _____ Work: _____

What Brings You to Therapy

Please describe what concerns you have regarding your child:_____
_____
_____
_____
How long has the problem existed? _____
Has your child had prior treatment? ☐Yes ☐ No If yes, please describe:_____
_____
What attempts have been made to resolve the difficulties?_____
_____

Psychiatrist/Prescriber:_____
Medications currently prescribed: Medication/Dosage _____
_____ _____
Significant medical problems/allergies:_____

Serious illnesses, accidents, or surgeries in the past:_____

Child's Development History

Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe:_____
_____

Did your child have health problems at birth? Yes _____ No _____ If yes, describe:_____
_____

3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)? Yes ___ No ___ Not sure_____

If yes, describe: _____

4. Did your child have any unusual behaviors or problems prior to age 3? Yes ___ No ___ Not sure_____ If yes, describe:
_____

Please circle if your child has experienced any of the following types of trauma or stressors:

Emotional Abuse	Neglect	Sexual Abuse
Lived in Foster Care	Multiple Family moves	Physical Abuse
Crime Victim	Homelessness	Parent Substance Use/Abuse
Parent Illness	Loss of pet or loved one.	Teen pregnancy
Adopted	Financial Stress/problems	Medical Problems
Parent Incarceration	Witness of Domestic Violence	No/Limited contact with a parent
Health Problems	DHS involvement	Other: