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INTAKE INFORMATION - CHILDREN

Father's name: _____ Home Phone _____ Cell _____
Marital Status _____ Soc. Sec. # _____ DOB _____ Email _____
Address _____ City _____ State _____ Zip Code _____
Employer _____ Work phone _____

Mother's name: _____ Home Phone _____ Cell _____
Marital Status _____ Soc. Sec. # _____ DOB _____
Email _____
Address _____ City _____ State _____ Zip Code _____
Employer _____ Work phone _____

Client Name _____ DOB _____ AGE _____
Address _____ City _____ State _____ Zip Code _____

1) **Sibling Name** _____ DOB _____ AGE _____
Address _____ City _____ State _____ Zip Code _____

2) **Sibling Name** _____ DOB _____ AGE _____
Address _____ City _____ State _____ Zip Code _____

3) **Sibling Name** _____ DOB _____ AGE _____
Address _____ City _____ State _____ Zip Code _____

Treatment History:

Primary Care Physician Name and Number: _____

Is the client currently taking medication? ____ If yes, please list name and dosage information:

Has the child ever been in therapy before? ____ If yes, please list dates and reason for treatment:

Children's Division Clients Only:

Please indicate the county in which your case is being handled: _____
Caseworker's Name: _____ Phone Number: _____
Medicaid Number: _____

Goals for Treatment:

Why have you decided to utilize art therapy services for your child or family?

INTAKE QUESTIONNAIRE - CHILDREN

Please complete the following questionnaire as thoroughly and completely as possible.

CLIENT NAME: _____ **DOB:** _____

Environment & Home:

Current Living Situation of Child: (Please check the appropriate box)

- Biological Parent
- Relative Home
- Foster Home
- Adoptive Home (Is client aware they are adopted? Y N)
- Domestic Violence Shelter
- Homeless Shelter
- Multiple Caregivers (Please describe): _____
- Other: _____

Please list the names, relationship (to child) and ages of other individuals in the home:

Childhood History: (Please check all that apply)

- Existing mental health/psychiatric diagnosis
- Prior mental health treatment
- Abuse (please specify type): _____
- Neglect
- Domestic Violence
- Prenatal exposure to drugs/alcohol
- Harm to self or others
- Suicidal thinking/threats
- Grief/Loss issues
- Past or present legal involvement (Check all that apply)
 - DFS Involvement
 - Custody Issues
 - Visitation Issues
 - Court Involvement
 - Hotline Calls (Current or Previous)
- Special learning needs
- Developmental Concerns

BEHAVIOR CHECKLIST

On the lines provided, put "0" to indicate NO CONCERN, "1" for LITTLE CONCERN, "2" for SOMEWHAT CONCERNED and "3" for VERY CONCERNED.

SLEEP PROBLEMS

- Difficulty falling asleep
- Nightmares
- Night terrors
- Awakens at night
- Refuses to sleep in own bed
- Wets the bed

EATING PROBLEMS

- Eats more than usual
- Eats less than usual
- Recent weight gain
- Recent weight loss

PHYSICAL PROBLEMS

- Frequent illness
- Wets or soils underwear
- Frequent accidental injuries
- Complains of pain
- Diagnosed with STD
- Frequent headaches

SOCIAL PROBLEMS

- Few friends
- Feels "picked on" by peers
- Runs away from home
- Sexual with other children
- Steals
- Fights/Bullies
- Lies
- Fear of males
- Does not trust
- Trusts strangers easily
- Clingy

EMOTIONAL PROBLEMS

- Frequent crying
- Anger outburst
- Tantrums
- Sets fires or plays with matches
- Cruel to animals
- Withdrawn
- Mood swings
- Sexual acting out
- Acts mature beyond age
- Acts younger prior to abuse
- Whines
- Sneaky
- Stares into space
- Has imaginary friends
- Hurts self physically
- Fear of being alone

SCHOOL PROBLEMS

- Poor grades
- Refuses to attend school
- Difficulty concentrating
- Acts ill to avoid school
- Sudden change in grades or performance

OTHER PROBLEMS

- Low motivation
- Less interest in appearance
- Less confidence in self
- Frequent masturbation
- Acts shameful about body
- Not respectful of boundaries
- Easily startled
- Acts seductive
- Use of drugs/alcohol

Completed by: _____

Relationship: _____

Discipline:

When disciplining your child, what methods do you use?

- Time-out
- Talking
- Spanking
- Taking away privileges
- Other: _____

What method(s) have been the most helpful? _____

What method(s) have been the least helpful? _____

Education:

Name of present daycare/school: _____ Grade: _____

Teacher's name: _____

Counselor's name: _____

Favorite subject: _____

Favorite activities outside of school: _____

Child's strengths: _____

Families strengths: _____

Family history: (Please check all that apply)

- History of mental health problems (i.e. depression, anxiety, schizophrenia)
- History of drug/alcohol abuse
- History of domestic violence
- Special learning needs
- Past or present legal involvement
- History of abuse (physical, sexual, verbal or emotional)
- Harm to self or others
- Suicidal thinking or threats
- Other: _____

Any recent deaths, births, moves within last 12 months: _____

Finances:

Is your family experiencing any significant financial problems?

Yes _____ No _____

If yes, please describe: _____

Religious & Spiritual Orientation:

Are there any religious/spiritual/cultural beliefs or practices of which you would like me to be aware?

Yes _____ No _____

If yes, please describe: _____

Signature: _____ Date: _____

Name of person providing information

Relationship to client