INSTITUTE FOR CHILDREN'S AID

Child and Family Counseling Services

ICA Services Intake Form

Date: _____

LEGAL Guardian Information

Name:		
Relationship to Child: ☐ Biological Parent(s) ☐ Adoptive Parent(s) ☐ Social Worker ☐ Other: Agency:		
Address:		
City:	State:	Zip:
Home Phone: ( )	Work Phone: ( )	
Cell Phone: ( )	Email Address:	
May we call you and leave messages at home? *Yes No* May we call you and leave messages at work? *Yes No* May we send mail to you at this address? *Yes No*		

Current Caregiver (who the child resides with)

☐ Same as Legal Guardian (fill in only information that is different from that listed above)		
Name:		
Relationship to Child: ☐ Foster Parent(s) ☐ Biological Relative ☐ Group Home ☐ Other: Specify:		
Address:		
City:	State:	Zip:
Home Phone: ( )	Work Phone: ( )	
Cell Phone: ( )	Email Address:	
May we call you and leave messages at home? *Yes No* May we call you and leave messages at work? *Yes No* May we send mail to you at this address? *Yes No*		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Spouse/Partner:		

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Household Information

Children in the home			
Name	**Date of Birth**	**Gender**	**Relationship to client**
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
Caregiver Occupations:			
Caregiver Highest Level of Education: ☐ Some High School ☐ High School Diploma ☐ Some College ☐College Degree ☐ Some Graduate Work ☐ Master's Degree ☐ Doctoral Degree			

Emergency Contact Information

Name:	Relationship to child:	
Home Phone: ( )	Work Phone: ( )	
Cell Phone: ( )	Email Address:	
Address:		
City:	State:	Zip:

Child to Receive Treatment – General Information

Name:	Date of Birth:	Gender: ☐Female ☐Male
Attending School:	Grade:	
Cell Phone: ( )	Email Address:	
How much contact per month does the child have with his/her biological mother/father:		
Extracurricular activities/interests:		

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Requested Services

Please check the corresponding box for the service(s) that you are requesting or for which you have been referred.

☐ Home-Based Individual Counseling	☐ Parenting Skills
☐ Home-Based Family Counseling	☐ Intensive Home-Based Clinical Mentoring
☐ Group Counseling	☐ Community Based Treatment (Wrap-Around Services)
☐ Art Therapy	☐ Home-Based Tutoring
☐ Visitation Supervision or Observation	☐ Home-Based Organizational Coaching
☐ Respite	☐ Other (Please Describe):

Reasons for Seeking Help

What concerns about the child have brought you to counseling?
Where are these concerns causing the most problems for YOU? (check all that apply) ☐ Home ☐ Work ☐ Marriage/Relationship ☐ Other
Where are these concerns causing the most problems for the CHILD? (check all that apply) ☐ Home ☐ School ☐ Friends ☐ Other
When did the present concerns begin to be a problem for the child?
What concerns about the child have been identified by others?

Please indicate which of the following are currently problems the child experiences. Check all that apply:

☐ Crying spells	☐ Hyperactivity
☐ Excessive fears or anxieties	☐ Bullying/picking fights
☐ Difficulty being away from specific family members	☐ Difficulty with authority
☐ Hearing voices	☐ Nightmares
☐ Getting into trouble at school/play	☐ Obsessions/compulsion with specific activities
☐ Temper tantrums	☐ Lack of motivation
☐ Difficulty falling asleep/inability to sleep at night	☐ Lack of self-confidence
☐ Decreased/increased appetite	☐ Difficulty making or keeping friends
☐ Loss of interest in usual activities	☐ Other(s):

Treatment & Psychiatric History

Has the child received previous treatment? ☐ Yes (complete the information below) ☐ No
When: For how long? For what reason?

Has the child ever been diagnosed with or treated for any type of mental illness?
☐ Yes ☐ No If yes, which type?

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness?
☐ Yes ☐ No If yes, which type?

Please list any psychiatric medications your child is currently taking:

Psychiatric Medication(s)	Dosage

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Medical History

How would you rate your child's current physical health?			
☐ Excellent	☐ Good	☐ Fair	☐ Poor

Is the child currently complaining of any physical problems (e.g., headaches, stomach aches)?
Yes ☐ No If yes, which type?

Primary Care Physician		
Name:		Associated Hospital:
Address:		
City:	State:	Zip:
Phone: ( )		Notes:

Preferred Hospital		
Name:		
Address:		
City:	State:	Zip:
Phone: ( )		Notes:

Previous hospitalizations for medical reasons:	
Date:	Reason:
Date:	Reason:

Please list any medical conditions or disabilities:
Please list any learning disabilities:
Please list any medications your child is currently taking:

Medication(s) ***Over-the-counter AND Prescription***	**Dosage**