Laura Molzer, MS, LMFT

Laura Molzer Therapy, LLC
1200 S. College Avenue, Suite 208
Fort Collins, CO 80524

Phone: (970) 672-5535
Fax: (970) 672-5536

CHILD INTAKE FORM

Thank you for taking the time to complete this form. The information and history you provide to me about your child will help me gain a better understanding of your child and help me to evaluate him/her. Please answer all questions and ask about any question you don't understand.

Today's Date: _____

How did you hear about me? Circle one:

☐ Family member ☐ Friend ☐ Internet ☐ Insurance ☐ Child Advocacy Center
☐ Other Therapist ☐ Doctor ☐ Brochure ☐ Attorney ☐ Department of Human Services

Other: _____

Indentifying Information

Child's Name: _____ Date of Birth: _____
Age: _____ Sex: _____ Race: _____ Religion: _____
School: _____ Teacher: _____ Grade: _____

Does your child experience any of the following at school? Please Circle.

☐ Poor Attendance ☐ Learning Disabilities ☐ Poor Grades ☐ Detention ☐ Suspension ☐ Fighting
☐ Lack of Friends ☐ Behavior Issues ☐ Bullying ☐ Drugs/Alcohol ☐ Poor Concentration

Other: _____

Parent/Guardian Name: _____ Date of Birth: _____
Age: _____ Sex: ☐ M or ☐ F Race: _____ Religion: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ Okay to leave a message? ☐ Y or ☐ N
Cell Phone Number: _____ Okay to leave a message? ☐ Y or ☐ N
Work Phone Number: _____ Okay to leave a message? ☐ Y or ☐ N
Occupation: _____ Place of Employment: _____
Marital Status: _____

Parent/Guardian Name: _____ Date of Birth: _____
Age: _____ Sex: ☐ M or ☐ F Race: _____ Religion: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ Okay to leave a message? ☐ Y or ☐ N
Cell Phone Number: _____ Okay to leave a message? ☐ Y or ☐ N
Work Phone Number: _____ Okay to leave a message? ☐ Y or ☐ N
Occupation: _____ Place of Employment: _____
Marital Status: _____

Family Composition

Name	Age	Date of Birth	Relationship	How well do they get along with other family members?

Does your child live in another household? If yes, please list the family members he/she lives with to the best of your ability.

Name	Age	Date of Birth	Relationship	How well do they get along with other family members?

Medical History

Child's primary care provider: _____

Medications child is currently taking: _____

_____

Has the child previously attended therapy? ☐ Y or ☐ N

Who did the child see? _____

Reason child was seen in therapy: _____

Type of therapy child received: _____

Was the therapy helpful? Circle one: ☐ Helpful ☐ Somewhat helpful ☐ Not helpful

Has your child experienced any of the following? Please circle and describe.

-chronic illness: _____

-surgeries: _____

-hospitalizations: _____

-high fevers: _____

-head injuries: _____

-seizures: _____

-eating problems: _____

-sleeping problems: _____

-encopresis/enuresis: _____

-problems with coordination: _____

-other: _____

Birth History

Is this your biological child? ☐ Y or ☐ N

If no, is this child adopted? ☐ Y or ☐ N

If yes, how old was the child when adopted? _____

If yes, does child know they were adopted? _____

Was the child's pregnancy planned? ☐ Y or ☐ N

Was the child born preterm, on time, or overdue? _____

Did the child or mother experience any problems during pregnancy? ☐ Y or ☐ N

If yes, please explain: _____

_____

Did the child or mother experience any complications during delivery? ☐ Y or ☐ N

If yes, please explain: _____

_____

Did the mother experience any depression after the baby's birth? ☐ Y or ☐ N

If yes, please explain: _____

_____

Current Stressors

Please circle any of the stressors your child has experienced over the last 12 months:

☐ Death of a parent	☐ Divorce of parents	☐ Separation of parents
☐ Remarriage of parents	☐ Death of a family member	☐ Death of a friend
☐ Personal injury or illness	☐ Parental job loss	☐ Sexual abuse (self)
☐ Sexual abuse (family member)	☐ Change in family member's health	☐ Birth of a sibling
☐ Alcohol/drug addiction in family	☐ Change in financial status (parents)	☐ Vacation
☐ Change in living condition	☐ Change in residence	☐ Change of school

Other: _____

_____

_____

Please describe why you are seeking therapy for your child at this time: _____

_____

_____

_____

How long have you been concerned for your child? _____

_____

What do you think the cause is of your concern? _____

_____

How have you tried to help your child so far? _____

_____

_____

Has your child ever tried to hurt or kill themselves? ☐ Y or ☐ N

If yes, please describe: _____

_____

_____

If yes, when did this occur? _____

What kind of discipline is used in your home? _____

_____

_____

Please circle all behaviors that apply to your child:

☐ Accident prone	☐ Aggressive	☐ Argumentative	☐ Bossy
☐ Breaks the rules	☐ Bullies others	☐ Bullied by others	☐ Cheats
☐ Complains often	☐ Conflict with parents	☐ Conflict with peers	☐ Conflict with siblings
☐ Cries easily	☐ Dawdles	☐ Daydreams	☐ Defiant
☐ Destructive	☐ Disruptive	☐ Easily Frustrated	☐ Fearful
☐ Fidgety	☐ Fighting	☐ Finger sucking	☐ Fire setting
☐ Hair Chewing/Pulling	☐ Head banging	☐ Hitting	☐ Hyperactive
☐ Imaginary friends	☐ Inattentive	☐ Interrupts	☐ Irritable
☐ Isolates self	☐ Lacks boundries	☐ Legal difficulties	☐ Lethargic
☐ Lies	☐ Manipulative	☐ Masterbates	☐ Moody
☐ Nail biting	☐ Nervous/anxious	☐ Nightmares	☐ Noncompliant
☐ Oppositional	☐ Physical complaints	☐ Poor concentration	☐ Provokes others
☐ Rages	☐ Repetitive movements	☐ Runs away	☐ Self-harm
☐ Sexual concerns	☐ Shy/timid	☐ Speech difficulties	☐ Steals
☐ Stubborn	☐ Swears	☐ Temper tantrums	☐ Tics
☐ Uncooperative	☐ Under-active	☐ Unhappy	☐ Violent
☐ Withdrawn			

Other: _____

Which of the above behaviors are the most concerning to you? _____

_____

Is there any other information that would be important for me to know about your child?

_____

_____

_____

_____

_____

Signature of Parent: _____ Date: _____

Signature of Therapist: _____ Date: _____