NEW ROOTS
counseling

CHILD INTAKE ASSESSMENT FORM

Luke Morrissey, EdS, LPC
Licensed Professional Counselor
2025 Ebenezer Rd, Suite M1, Rock Hill, SC 29732-2255
Phone: (803) 325-2255 | E-mail: luke@newrootscounseling.co

IDENTIFYING INFORMATION

Child's name: _____
Today's date: _____ Date of birth: _____ Age: _____ Grade:_____
Race/ethnicity: _____ Religious affiliation: _____
Person(s) completing this form: _____
Who suggested that you contact me: _____

Child's custodian/guardian(s) is/are:_____

Are parents divorced or separated? _____ Were parents ever married? ☐ Yes ☐ No
If child's parents are divorced or separated, who has legal custody? _____

How often does the non custodial parent see this child?

☐ Weekly or more often ☐ Once or twice a month ☐ Few times a year ☐ Almost never If parents have joint custody, how is child's visitation split? _____
Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ☐ Yes ☐ No If yes, describe: _____
_____

Child's Home Address: _____
City _____ State _____ Zip Code _____
Home Telephone: _____ Other Phone (specify type): _____

**Is it okay to leave a (phone or text) message? ☐ yes ☐ no
Special instructions? _____

Your confidentiality cannot be ensured/guaranteed with unsecured phone and text messages. You are waiving your HIPPA guaranteed privacy by agreeing "yes" to receive or send text or phone messages. Please do not text the counselor with specific information you would like to keep confidential.

Emergency Contact Name: _____ Relationship to Child: _____
Address: _____
City _____ State _____ Zip Code _____
Home Telephone: _____ Other Phone (specify type): _____

NEW ROOTS
counseling

MOTHER'S INFORMATION

Mother's name: _____ Date of birth: _____
Mailing Address: _____
Home phone: _____ E-Mail:_____
Race/ethnicity: _____ Religious affiliation: _____
Highest Grade or Degree Completed: _____

Marital/relationship status (Check one):

☐ Married ☐ Live with partner ☐ Single ☐ Separated/Divorced ☐ Widowed ☐ Other: _____

Employment status (Check all that apply):

☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed

Current employer is: _____ Type of work: _____
Years on current job: _____ Business Phone: _____

Is it okay to contact the client's mother at work? ☐ yes ☐ no Is it okay to leave a message? ☐ yes ☐ no
Special calling instructions? _____

FATHER'S INFORMATION

Father's name: _____ Date of birth:_____
Mailing Address: _____
Home phone: _____ E-Mail:_____
Race/ethnicity: _____ Religious affiliation: _____
Highest Grade or Degree Completed: _____

Marital/relationship status (Check one):

☐ Married ☐ Live with partner ☐ Single ☐ Separated/Divorced ☐ Widowed ☐ Other: _____

Employment status (Check all that apply):

☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed

Current employer is: _____ Type of work: _____
Years on current job: _____ Business Phone: _____

Is it okay to contact the client's father at work? ☐ yes ☐ no Is it okay to leave a message? ☐ yes ☐ no
Special calling instructions? _____

NEW ROOTS
counseling

STEP-PARENT'S INFORMATION *(fill in if applicable)*

Step-parent's name: _____ Date of birth: _____
Mailing Address: _____
Home phone: _____ E-Mail:_____
Race/ethnicity: _____ Religious affiliation: _____
Highest Grade or Degree Completed: _____

Marital/relationship status (Check one):

☐ Married ☐ Live with partner ☐ Single ☐ Separated/Divorced ☐ Widowed ☐ Other: _____

Employment status (Check all that apply):

☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed

Current employer is: _____ Type of work: _____
Years on current job: _____ Business Phone: _____

Is it okay to contact the client's step-parents at work? ☐ yes ☐ no

Is it okay to leave a message? ☐ Yes ☐ No Special calling instructions? _____

STEP-PARENT'S INFORMATION *(fill in if applicable)*

Step-parent's name: _____ Date of birth: _____
Mailing Address: _____
Home phone: _____ E-Mail:_____
Race/ethnicity: _____ Religious affiliation: _____
Highest Grade or Degree Completed: _____

Marital/relationship status (Check one):

☐ Married ☐ Live with partner ☐ Single ☐ Separated/Divorced ☐ Widowed ☐ Other: _____

Employment status (Check all that apply):

☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed

Current employer is: _____ Type of work: _____
Years on current job: _____ Business Phone: _____

Is it okay to contact the client's step-parents at work? ☐ yes ☐ no

Is it okay to leave a message? ☐ Yes ☐ No Special calling instructions? _____

NEW ROOTS
counseling

REASON FOR SEEKING TREATMENT

Please briefly describe the problems your child is experiencing.

_____
_____
_____
_____

What has happened to cause you to seek help NOW? _____
_____
_____

What do you hope to be able to do or achieve as a result of counseling?

_____
_____
_____

What do you consider to be other stresses in your child's life? _____
_____
_____

CURRENT DIAGNOSIS

Diagnosis	Diagnosed by	Date	Describe any symptoms

NEW ROOTS
counseling

HISTORY OF THE PROBLEM

Approximately, when did your child first start experiencing the problem(s) or concerns that brought you to the office today? _____

How often does the problem or concern occur? _____

How long does it last? _____

Does your child have any thoughts of harming him/herself? ☐ No ☐ Yes
If yes, please explain: _____

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
If yes, please explain: _____

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 explain if it was helpful and why:_____
_____

To your knowledge, has your child experimented with alcohol/drugs? ☐ No ☐ Yes

If yes, please explain:
_____
_____

Are you concerned that your child may have or be developing a problem with alcohol/drugs? ☐ No ☐ Yes
If yes, please explain: _____
_____
_____

NEW ROOTS
counseling

FAMILY

Has your 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.

_____
_____
_____
_____

Please list the details of the client's siblings (including those deceased, step, and half siblings):

Name of siblings	Age	Gender	Lives with client	Living	Relation	Relationship Quality with client
		☐F ☐M	☐yes ☐no	☐deceased	☐step ☐half	☐poor ☐average ☐good ☐great
		☐F ☐M	☐yes ☐no	☐deceased	☐step ☐half	☐poor ☐average ☐good ☐great
		☐F ☐M	☐yes ☐no	☐deceased	☐step ☐half	☐poor ☐average ☐good ☐great
		☐F ☐M	☐yes ☐no	☐deceased	☐step ☐half	☐poor ☐average ☐good ☐great
		☐F ☐M	☐yes ☐no	☐deceased	☐step ☐half	☐poor ☐average ☐good ☐great

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

Name	Age	Gender	Relation to the client	Relationship Quality with client
		☐F ☐M		☐poor ☐average ☐good ☐great
		☐F ☐M		☐poor ☐average ☐good ☐great
		☐F ☐M		☐poor ☐average ☐good ☐great
		☐F ☐M		☐poor ☐average ☐good ☐great

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): _____

NEW ROOTS
counseling

PARENTING, DISCIPLINE, & FAMILY ROLES

What do you use as discipline? _____
Does it work (explain)? _____
What else have you used in the past, and did it work? _____
_____

Do you all guardians of the child agree on parenting/discipline styles? ☐ No ☐ Yes Explain:
_____
If you and the other parent are separated or divorced, how do you handle shared parenting?_____
_____
If you are a single parent, how do you manage the stress of parenting alone? _____
_____
How does your child respond to discipline? _____
What role does your child have in the home and how is this different from others in the home? _____
_____
_____

Who handles responsibility for your child in the following areas?

School:	☐Mother ☐Father ☐Shared ☐Other (specify):_____
Health:	☐Mother ☐Father ☐Shared ☐Other (specify): _____
Problem behavior:	☐Mother ☐Father ☐ Shared ☐Other (specify): _____

CULTURAL/ETHNIC BACKGROUND

To which cultural or ethnic group, if any, do you belong?_____
Are you experiencing any problems due to cultural or ethnic issues? ☐ No ☐ Yes
If yes, describe: _____
Other cultural/ethnic information: _____

SPIRITUAL/RELIGIOUS CONSIDERATIONS

How important to your child are spiritual matters? Not / Little / Moderate / Much
Is your child affiliated with a spiritual or religious group? ☐ No ☐ Yes
If yes, describe: _____
Is your family affiliated with a spiritual or religious group? ☐ No ☐ Yes
If yes, describe: _____
Would your child like your spiritual/religious beliefs incorporated into the counseling? ☐ No ☐ Yes
If yes, describe: _____

NEW ROOTS
counseling

FAMILY HEALTH

Describe father's present health: _____
Describe mother's present health: _____

Have any family members had any of the following (PLEASE CHECK IF YES)?
If yes, please specify family member's relationship to this child.

Health Condition	Relationship to you	Health Condition	Relationship to you
☐ Cancer		☐ Severe head injury	
☐ Tourette's syndrome		☐ Learning Problems	
☐ Diabetes		☐ Food allergies	
☐ Heart disease		☐ Alcohol/drug abuse	
☐ High blood pressure		☐ Nervousness	
☐ Behavior disorder		☐ Migraine headaches	
☐ Depression		☐ Multiple sclerosis	
☐ Mental Illness		☐ Physical disability	
☐ Mental retardation		☐ Stroke	
☐ Seizures/epilepsy		☐ Alzheimer's disease	
☐ Speech/language problem		☐ Sickle cell anemia	
☐ Sleep Difficulties		☐ Tics	
☐ Anxiety		☐ Bipolar Disorder	
☐ Attention Deficit/Hyperactivity Disorder			
☐ Other significant health or emotional problem			

What kinds of stressful events has your child experienced recently? _____
_____
What kinds of stressful events have family members experienced recently? _____
_____

CHILD'S EDUCATION

Current school: _____ School phone number: _____
Type of school: ☐Public ☐Private ☐Home schooled ☐Other (specify):_____
Grade: _____ Teacher(s):_____ School Counselor: _____
In special education or have an IEP? ☐Yes ☐No If Yes, describe: _____
In gifted program? ☐Yes ☐No If Yes, describe: _____
Has child ever been held back in school? ☐Yes ☐No If Yes, describe:_____

Which subjects does the child enjoy in school? _____
Which subjects does the child dislike in school? _____
What grades does the child usually receive in school? _____
Have there been any recent changes in the child's grades? ☐Yes ☐No
If yes, describe: _____

Has the child been tested psychologically? ☐Yes ☐No
If yes, describe: _____

Check the descriptions which specifically relate to your child.
Feelings about School Work: ☐Anxious ☐Passive ☐Enthusiastic ☐Rebellious ☐Eager ☐Fearful
☐Bored ☐No expression ☐Other (describe):_____

Approach to School Work: ☐Organized ☐Industrious ☐Doesn't complete assignments ☐Responsible
☐Interested ☐Sloppy ☐Self-directed ☐Does only what is expected ☐No initiative ☐Refuses
☐Disorganize ☐Cooperative ☐Other (describe):_____

Performance in School (Parent's Opinion): ☐Satisfactory ☐Overachiever ☐Underachiever ☐Other (describe):_____

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

Child's Peer Relationships: ☐Follower ☐Leader ☐Shares easily ☐Spontaneous ☐Makes friends easily
☐Long-time friends ☐Difficulty making friends ☐Other(describe):_____

Child's Work Experience:
If the child is involved in a vocational program or works a job, *please fill in the following:*

What is the child's attitude toward work? ☐Poor ☐Average ☐Good Excellent

Current employer_____ Position_____ Hours per week _____
How have the child's grades in school been affected since working? ☐Lower ☐Same ☐Higher How many previous jobs or placements has the child had?_____
Usual length of employment: _____ Usual reason for leaving: _____

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:
_____
_____
_____

This child was ☐ breast fed ☐ formula fed ☐ both. When was she/he weaned? _____
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 or Learning 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:_____

NEW ROOTS
counseling

CHILD'S DEVELOPMENT(continued)

Where there other problems experienced during the child's first year? ☐ No ☐ Yes If yes, describe:

_____

Compared with others in the family, child's development was: slow average fast

Age for following occurrences *(fill in where applicable)*

☐Began puberty:_____ ☐Menstruation:_____ ☐Voice change:_____

☐Convulsions: _____☐Breast development: _____☐Injuries or hospitalization:_____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)
If Yes, describe:_____

CHILD'S MEDICAL CARE HISTORY

Child's physician: _____ Telephone: _____
Address: _____
How often does this child see a doctor? _____ Date of last visit: _____

Does your child have any history of the following *(please check all that apply)*:

☐Abortion	☐Hay-fever	☐Pneumonia	☐Asthma
☐ Head injuries	☐Polio	☐Blackouts	☐Heart trouble
☐Pregnancy	☐Bronchitis	☐Hepatitis	☐Rheumatic Fever
☐Cerebral Palsy	☐Hives	☐Scarlet Fever	☐Chicken Pox
☐Influenza	☐Seizures	☐Congenital problem	☐Lead poisoning
☐Severe colds	☐Croup	☐Measles	☐Severe head injury
☐Diabetes	☐Meningitis	☐STDs	☐Diphtheria
☐Miscarriage	☐Thyroid disorders	☐Dizziness	☐Multiple sclerosis
☐Vision problems	☐Ear aches	☐Mumps	☐Wearing glasses
☐Ear infections	☐Muscular Dystrophy	☐Whooping cough	☐Eczema
☐Nose bleeds	☐Fevers	☐Encephalitis	☐Other skin rashes
☐Paralysis	☐Other_____		

List any current health concerns: _____

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

Condition/hospitalization	Age	Treated by whom?	Outcome of treatment

List any recent health or physical changes: _____

Please *check* if there have been any recent changes in the following:

☐Sleep patterns

☐Eating patterns

☐Behavior

☐Energy level

☐General disposition

☐Weight

☐Nervousness/tension

☐Physical activity level

Describe changes in areas in which you checked above: _____

EXAMINATIONS *(Please list all that apply below)*

Examination Type	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last vision exam			
Last hearing exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

NEW ROOTS
counseling

MEDICATIONS

Current prescribed medications	Dose	Dates	Purpose	Noted Side effects

Allergic to any medications or drugs? ☐ No ☐ Yes If Yes, please describe._____

NUTRITION

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____/ week		☐None ☐Small ☐ Med ☐Large
Lunch	____/ week		☐None ☐Small ☐ Med ☐Large
Dinner	____/ week		☐None ☐Small ☐ Med ☐Large
Snacks	____/ week		☐None ☐Small ☐ Med ☐Large

How often does your child exercise? _____ What activities?_____
_____

How well does your child sleep?_____
_____

Average hours of sleep_____Weekdays_____ Weekends_____

NEW ROOTS
counseling

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._____
_____
_____

Thank you for your time and cooperation,

Luke T Morrissey Ed.S.
Licensed Professional Counselor

FOR COUNSELOR'S USE:

Counselor's Comments:
_____
_____
_____
_____

Physical exam: ☐ required ☐ not required at this time