



# CHILD INTAKE INFORMATION

Safe Families *for* Children

Child's Name \_\_\_\_\_ Parent Phone # \_\_\_\_\_

Nickname (if any) \_\_\_\_\_

## General Information

Languages spoken in the home? \_\_\_\_\_

What is the family's religious preference? \_\_\_\_\_

## Health and Development

**Current Medications** \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

**Does your child have any allergies?** \_\_\_\_\_

Does he/she have a regular diet? \_\_\_\_\_

Special foods? \_\_\_\_\_

### **For Infant:**

Type of formula/frequency of bottles: \_\_\_\_\_

Does your child have a bedtime routine? \_\_\_\_\_

Has your child had any unusual illness, injury, or operation?  Yes  No If yes, please explain: \_\_\_\_\_

**List any other health problems or concerns:** \_\_\_\_\_

Are your child's vision / hearing normal?  Yes  No If no, please explain: \_\_\_\_\_

Are your child's immunizations up to date?  Yes  No If not, why? \_\_\_\_\_

What situations, relationships, or events tend to be hardest or most upsetting for this child? \_\_\_\_\_

What comforts your child? \_\_\_\_\_

**For infants, STOP HERE**

**Education – School aged or preschool children**

School Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Start and End Time: \_\_\_\_\_ Special Ed. Needs: \_\_\_\_\_

How long attended? \_\_\_\_\_ IEP? \_\_\_\_\_

**Social**

What does your child like to do at home? \_\_\_\_\_

What scares/fears does your child have? \_\_\_\_\_

Discipline / Training at home includes... (Check all that apply)     Time-outs     Spanking  
 Loss of privileges/ rewards     Discussing Behavior     Other, explain \_\_\_\_\_

**Child's Behavior**

Current academic or behavioral problems? \_\_\_\_\_

***Please check all that apply to your child:***

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Depressed        | <input type="checkbox"/> Overactive                | <input type="checkbox"/> Nightmares               | <input type="checkbox"/> Runs away          |
| <input type="checkbox"/> Anxious          | <input type="checkbox"/> Easily frustrated         | <input type="checkbox"/> Sleep difficulties       | <input type="checkbox"/> Wants to die       |
| <input type="checkbox"/> Fearful          | <input type="checkbox"/> Peer problems             | <input type="checkbox"/> Eating difficulties      | <input type="checkbox"/> Uses drugs/alcohol |
| <input type="checkbox"/> Withdrawn        | <input type="checkbox"/> School problems           | <input type="checkbox"/> Wets Bed                 | <input type="checkbox"/> Truant             |
| <input type="checkbox"/> Low self-esteem  | <input type="checkbox"/> Sexualized behavior       | <input type="checkbox"/> Temper tantrums          | <input type="checkbox"/> Hurts him/herself  |
| <input type="checkbox"/> Poorly motivated | <input type="checkbox"/> Touches private parts     | <input type="checkbox"/> Aggressive toward others | <input type="checkbox"/> Plays with fire    |
| <input type="checkbox"/> Daydreams        | <input type="checkbox"/> History of sexual abuse   | <input type="checkbox"/> Destroys property        | <input type="checkbox"/> Steals             |
| <input type="checkbox"/> Distractible     | <input type="checkbox"/> History of physical abuse | <input type="checkbox"/> Other _____              |   |

Any other helpful information regarding your child... \_\_\_\_\_