Kristine Hutchison, PhD, LLC
4055 Executive Park Drive, Suite 210
Cincinnati, OH 45241
513-469-6226

Client Intake Form – MINOR

Today's Date_____

Client Name_____ DOB_____ Phone_____

Address_____ City_____ State_____ Zip_____

Gender _____ Ethnicity _____

Parent's Name_____ DOB_____

Parent's Address _____

Phone _____ email_____

Parent's Name_____ DOB_____

Parent's Address _____

Phone _____ email_____

Parents Married to each other: ____ No ____ Yes

Divorced/separated? ____No _____Yes If yes, when? _____

Step Parent's Name _____ DOB_____

Phone_____

Step Parent's Name _____ DOB_____

Phone_____

Siblings Name(s) and DOB

_____

_____

_____

Previous Psychological Treatment ____No ____Yes

If yes, Where_____ When_____

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Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check any that apply and list family member, e.g., siblings, parents, uncle, etc.)

Depression _____ Alcohol/Substance Abuse_____

Bipolar Disorder _____ Eating Disorders _____

Anxiety/Panic attacks_____ Learning Disabilities_____

Autism Spectrum_____ Schizophrenia_____

ADHD _____ Suicide Attempt(s) _____

OCD_____ Other_____

Birth and Developmental History

Were there any difficulties in the pregnancy or delivery with this child? ____No ____Yes

If yes, please explain_____

Was the child born: ____ full term _____premature

If premature, how early was the child born? _____

Has the child ever participated in: Speech therapy ___No ____ Yes

Occupational therapy ____ No _____ Yes Physical therapy ____No ____ Yes

If yes to any of these therapies, please explain _____

_____

Social

Does your child have: ____a lot of friends ____a few friends _____no friends

Does your child have problems with peers? ____No ____Yes

If yes, please explain _____

Are you concerned about your child's friendships? _____No _____Yes

If yes, please explain _____

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Health Information

How is your child's physical health at present? ___Poor ____Satisfactory ____Very Good

If poor, please explain _____

Please list all ongoing health concerns of the child (e.g., headaches, diabetes, etc) _____

_____

Please list all medications taken by the child (including dosages)_____

_____

_____

_____

Does your child have any allergies (environmental, food, medication)? ___No ___Yes

If yes, please explain_____

Does your child have any problems with sleep? ___No ___ Yes

If yes, please explain _____

Does your child have any struggles with eating ____ No ____ Yes

If yes, please explain _____

How often does your child get physical activity? _____

School Information

School now attending_____ Grade _____

Does your child have a 504 or IEP? ___No ___Yes

If yes, please bring a copy with you to the appointment.

Does your child have problems learning? ____No ____ Yes

If yes, please explain _____

Does your child have problems with his/her behavior in school? ____ No ____ Yes

If yes, please explain _____

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Has your child ever experienced any of the following (check all that apply)?

____Depressed mood
____Anxiety/Panic Attacks
____Hair pulling
____Mood swings
____Problems concentrating
____Hyperactive behavior
____Sleep disturbances
____Hallucinations
____Autism Spectrum Disorder
____Cutting oneself on purpose
____Speaking only around certain people
____Excessive defiant behaviors
____Frequent physical complaints
____Eating disorder
____Toileting struggles
____Repetitive thoughts (e.g., obsessions)
____Repetitive behaviors (e.g., checking or hand-washing)
____Learning disabilities
____Suicidal thoughts/attempts
____Homicidal thoughts

If yes to any of the above, please explain _____

_____

_____

_____

_____

_____

Substance Use

Does your child smoke cigarettes? ___No ___Yes If yes, how often?_____

Does your child drink alcohol? ____No ____ Yes If yes, how often/much? _____

Does your child engage in recreational drug use? ___No ___Yes

If yes, what kind? _____ how often/how much? _____

Has your child previously been treated for substance abuse? ___No ___Yes

If yes, where_____ when_____

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Additional Information

In the last year, has your child experienced any significant life changes or stressors? ___No ___Yes

If yes, please explain _____

_____

_____

Has your child ever been physically or sexually abused? ____No ____Yes

If yes, please explain_____

_____

_____

What is your child's sexual orientation? _____

What do you consider to be your child's strengths? _____

_____

_____

What is your biggest concern regarding your child? _____

_____

_____

What changes would you like to see in the therapy process? _____

_____

_____

Any other information that you would like to share about your child? _____

_____

_____

How did you hear about my practice? _____

_____