Cooper
Therapy Connections PLLC
Speech and Language, Evaluation, Counseling, Feeding, Tutoring, and Occupational Therapy
(779) 234-8997

COUNSELING INTAKE FORM (under 18)

TODAY'S DATE: _____

CLIENT NAME: _____ NICKNAME:_____

DOB: _____AGE: _____ ☐ Male ☐ Female

Diagnosis (if known): _____

Home Address: _____ City, State, Zip: _____

Parent Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Parent Phone #2:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Parent Email #1:_____

Parent Email #2: _____

Emergency Contact

Name: _____

Relationship to child: _____

Contact Information: _____

HEALTH

Client's Physician: _____ Phone Number:_____

Physician's Address: _____

Other Physicians / Specialists Involved In Care:

Referring Physician: _____ Phone Number _____ Physician Address: _____

Secondary Physician: _____ Phone Number _____

Physician Address: _____

Family Background

Parent 1 Name: _____ Age: _____

Occupation: _____ Education Level: _____

Parent 2 Name: _____ Age: _____

Occupation: _____ Education Level: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

What adults does the child live with? Check all that apply:

☐ Birth Parent(s)

☐ Adoptive Parent(s)

☐ Foster Parent(s)

☐ Grandparent(s)

☐ Both Parents

☐ Parent 1 Only

☐ Parent 2 Only

☐ Other:

_____

Language(s) spoken in the home: _____

Who speaks the other language(s)? _____

Describe the child's use/understanding of the language(s):

Is there anything additional you would like to share about the family / home environment?

Current Status

Please describe the present concerns(s):

Estimate date concerns began: _____

Previous or current therapist(s): _____

Previous or current treatment for concerns: _____

What are you expecting out of this evaluation / meeting?

Medical History

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:

Mother's Health During Pregnancy:

1. Were there any infections or illnesses? ☐ Yes ☐ No

Describe: _____

2. Was there any stress during the pregnancy? ☐ Yes ☐ No

Describe: _____

3. Were there any complications during labor or delivery? ☐ Yes ☐ No

Describe: _____

4. What was the mother's age at the time of delivery? ____ years

Child's Health:

1. How many weeks gestation was the child born? _____ weeks (40 is typical)

2. The child was _____ lbs ____oz and _____ inches at birth

3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section

4. Please describe any complications or concerns during labor or delivery:

Check and describe all that apply:

☐Anxiety	☐Appetite Issues	☐Suspiciousness
☐Depression	☐Excessive Energy	☐Avoidance
☐Hallucinations	☐Impulsivity	☐Fatigue
☐Loss of Interest	☐Mood Swings	☐Irritability
☐Sleep Changes	☐Panic Attacks	☐Racing Thoughts
		☐Crying Spells

For those that were checked above, please describe:

Has the child ever experienced trauma (medical, emotional, etc.)? ☐ Yes ☐ No

Please describe:

Is the child currently on any medications? If so, please list medication name and reason for medication:

Medication 1: _____

Medication 2: _____

Medication 3: _____

Medication 4: _____

Does the child have any known allergies? ☐ Yes ☐ No

Describe:

Describe the child's current health status:

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

☐ Developmental Pediatrician _____

☐ Neurologist _____

☐ PT _____

☐ OT_____

☐ SLP _____

☐ Behavioral Therapist _____

☐ Educational Consultant _____

☐ Psychologist / Psychiatrist _____

☐ Vision Therapist _____

☐ Other: _____

What are your goals for the child over the next 3 months?

What are your goals for the child over the next 6 months?

What are your goals for the child over the next 5 years?

Is there anything else that is important for us to know about the child?

How did you hear about Cooper Therapy Connections PLLC?

Person filling out the form: _____

Signature: _____ Date:_____

Relationship to the child: _____