BELLA COACHING SERVICES
815 MAIN STREET | SAINT JOSEPH, MICHIGAN

CHILD INTAKE FORM

ADHD Coaching + Educational Therapy

Child

1. CHILD'S NAME SEX AGE DOB

2. NATURAL CHILD IF ADOPTED, AT WHAT AGE FOSTER SINCE

3. PARENT'S NAMES (INCLUDE STEP-PARENTS, FOSTER PARENTS, INC.)

4. COMMENTS ABOUT CUSTODY AND VISITATION (IF APPLICABLE):

5. PRIMARY REASON YOU ARE CONCERNED ABOUT YOUR CHILD?

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

A.

- ☐ SLEEP PROBLEMS
- ☐ LACK OF INTEREST IN ACTIVITIES
- ☐ UNASSERTIVE
- ☐ FATIGUE/LOW ENERGY
- ☐ CONCENTRATION PROBLEMS
- ☐ APPETITE/WEIGHT CHANGES
- ☐ WITHDRAWAL
- ☐ MORBID THOUGHTS
- ☐ SUICIDAL THOUGHTS OR THREATS
- ☐ SUICIDAL PLANS / ATTEMPTS
- ☐ MOOD SWINGS
- ☐ DEPRESSION
- ☐ CHANGED LEVEL OF ACTIVITY
- ☐ CRIES EASILY

B.

- ☐ FORGETFUL/MEMORY PROBLEMS
- ☐ SHORT ATTENTION SPAN
- ☐ AGGRESSIVE BEHAVIOR
- ☐ CAN'T SIT STILL
- ☐ NOT INTERESTED IN PEERS
- ☐ PICKED ON / BULLIED BY PEERS
- ☐ TALKS EXCESSIVELY / INTERRUPTS
- ☐ EASILY DISTRACTED
- ☐ IRRITABLE
- ☐ IMPULSIVE
- ☐ DIFFICULTY FOLLOWING RULES
- ☐ PROBLEM COMPLETING SCHOOLWORK

C.
- ☐ EXCESSIVE WORRY / FEARFULNESS
- ☐ ANXIETY OR PANIC ATTACKS
- ☐ SOCIAL FEARS, SHYNESS
- ☐ SEPARATION PROBLEMS
- ☐ BEDWETTING / SOILING
- ☐ HEADACHES, STOMACHACHES
- ☐ ODD BELIEFS / FANTASIZING
- ☐ NIGHTMARES
- ☐ FREQUENT TANTRUMS
- ☐ RESISTIVE TO CHANGE
- ☐ SCHOOL REFUSAL
- ☐ PERFECTIONISM
- ☐ ODD HAND / MOTOR MOVEMENTS
- ☐ HALLUCINATIONS

B.
- ☐ LYING
- ☐ TROUBLE WITH THE LAW
- ☐ RUNNING AWAY
- ☐ TRUANCY, SKIPPING SCHOOL
- ☐ HURTING OTHERS SEXUALLY
- ☐ ALCOHOL / DRUG USE
- ☐ ARGUMENTATIVE / DEFIANT
- ☐ SWEARS
- ☐ BLAMES OTHERS FOR MISTAKES
- ☐ STEALING
- ☐ BEING DESTRUCTIVE
- ☐ FIRE SETTING
- ☐ HURTING OTHERS / FIGHTING
- ☐ ACTS AS IF HAS NO FEAR
- ☐ SHORT TEMPERED
- ☐ EASILY ANNOYED / ANNOYS OTHERS
- ☐ DISCIPLINE PROBLEM
- ☐ ANGRY AND RESENTFUL

Brothers and Sisters

FIRST NAME – LAST NAME	SEX	AGE	RELATIONSHIP TO CHILD (FULL, STEP, HALF, FOSTER)
1.			
2.			
3.			
4.			
5.			
6.			

SCHOOL HISTORY

1. PRESENT SCHOOL: _____ GRADE: _____ TEACHER: _____

2. HAS CHILD EVER REPEATED ANY GRADE? _____

3. IS CHILD IN SPECIAL EDUCATION SERVICES? NO _____ YES, WHAT KIND? _____

4. PLEASE DESCRIBE ACADEMIC OR OTHER PROBLEMS YOUR CHILD HAS HAD IN SCHOOL

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. Pregnancy

MOTHER USED DURING PREGNANCY ☐ ALCOHOL ☐ DRUGS ☐ CIGARETTES

DELIVERY: ☐ NORMAL ☐ BREECH ☐ CESAREAN ☐ TRANSECTIONAL

☐ FULL-TERM ☐ PREMATURE ☐ IF PREMATURE, NUMBER OF WEEKS

BIRTH WEIGHT:

PROBLEMS AT BIRTH: (FOR EXAMPLE: INFANT GIVEN OXYGEN, BLOOD TRANSFUSION, PLACED IN AN INCUBATOR, ETC)

2. Developmental History

STATE APPROXIMATE AGE WHEN CHILD DID THE FOLLOWING:

WALKED ALONE SAID FIRST WORD USED 2-WORD PHRASES

UNDERSTOOD AND FOLLOWED SIMPLE DIRECTIONS

REASONABLY WELL TOILET TRAINED

DID CHILD CRY EXCESSIVELY? RARELY CRIED

3. Health History of Child

IN THE FIRST TWO YEARS, DID YOUR CHILD EXPERIENCE:

☐ SEPARATION FROM MOTHER, ☐ OUT OF HOME CARE ☐ DISRUPTION IN BONDING ☐ ABUSE

☐ DEPRESSION OF MOTHER ☐ NEGLECT ☐ CHRONIC PAIN ☐ CHRONIC ILLNESS ☐ PARENTAL STRESS

CHILD'S DOCTOR:

DATE OF LAST PHYSICAL EXAM:

VISION PROBLEMS? HEARING PROBLEMS?

DENTAL PROBLEMS?

ANY HEAD INJURIES OR LOSS OF CONSCIOUSNESS?

CHILD'S HISTORY OF SERIOUS ILLNESS, INJURY, HANDICAPS, OR HOSPITALIZATION?

DESCRIBE AND GIVE DATES

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS?

NAME MEDICATIONS

LIST ANY MEDICINES PREVIOUSLY USED FOR EMOTIONAL PROBLEMS: WERE THEY HELPFUL?

ALLERGIES TO DRUGS OR MEDICINES? (LIST)

ALLERGIES TO ANY FOODS? (LIST)

ARE THERE ANY FOODS THAT YOU LIMIT OR DO NOT GIVE THIS CHILD?

(LIST)

ALLERGIES TO ENVIRONMENTAL CONDITIONS? (LIST)

DOES ANYONE IN THE HOUSEHOLD SMOKE?

ABOUT HOW MANY HOURS DOES THIS CHILD WATCH TV, VIDEOS, ETC PER DAY

ARE YOU AFRAID SOMEONE YOU KNOW MAY INJURE/HARM THIS CHILD?

NATIONAL DOMESTIC VIOLENCE HOTLINE 1-800-799-7233

DOES THIS CHILD HAVE A HEALTH CARE DIRECTIVE?

IF YES, PLEASE LIST WHERE (CLINIC) IT IS ON FILE

ANY PREVIOUS PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT?

WHOM/WHERE WHEN

ANY PREVIOUS TESTING (SCHOOL/PSYCHOLOGICAL)?

WHOM/WHERE

DO YOU THINK YOUR CHILD'S USE OF CHEMICALS IS A PROBLEM?

TYPE: ALCOHOL MARIJUANA OTHER DRUGS

COMMENTS:

4.Family History:

CHEMICAL USE (NOW & PAST): WHICH PARENT

TYPE: ALCOHOL MARIJUANA OTHER DRUGS

LIST ANY HISTORY OF MENTAL ILLNESS OR ADDICTION IN IMMEDIATE OR EXTENDED FAMILY (EX: DEPRESSION, ANXIETY, BI-POLAR DISORDER, SUICIDE ATTEMPTS, ALCOHOLISM, DRUGS, ADHD, SCHIZOPHRENIA, ETC.):

HAS CHILD WITNESSED DOMESTIC VIOLENCE? SPECIFY:

HOW IS YOUR CHILD DISCIPLINED? PLEASE LIST EACH METHOD AND FREQUENCY OF USE:

5.LIFE STRESSORS/TRAUMA HISTORY

1. HAS YOUR CHILD BEEN VERBALLY ABUSED? SPECIFY:

2. HAS YOUR CHILD BEEN PHYSICALLY ABUSED? SPECIFY:

3. HAS YOUR CHILD BEEN SEXUALLY ABUSED? SPECIFY:

4. OTHER STRESSORS OR TRAUMAS?

WHAT ARE YOUR CHILD'S STRENGTHS?

ANY ADDITIONAL COMMENTS OR INFORMATION THAT WOULD BE HELPFUL TO US?

SIGNATURE OF PERSON COMPLETING FORM / RELATIONSHIP TO CLIENT:

NAME RELATIONSHIP DATE: