Charis Institute for Psychological and Family Services
21 Southgate Court, Suite 101
Harrisonburg, VA 22801
Phone: 540.568.1876

Children's Intake Form

Where did you hear about our services or who referred you_____

General Information

_____ _____/_____/_____ _____ - _____ - _____
Name Date of Birth Social Security Number

_____ _____
Mailing Address City, State Zip School/Grade

Person Responsible For Account

_____ _____ - _____ - _____ (___)_____
Name Social Security Number Home Phone

_____ (___)_____
Mailing Address City, State Zip Cell Phone

For your comfort and assurance of confidentiality we ask that you please read over the following and check your preferences.

- I give permission for Charis to call my home and leave a message on the answering machine or with anyone who answers the phone.
- I give permission for Charis to call my work number if I need to be reached.

_____ _____/_____/_____
Signature **Date**

Father

_____ _____/_____/_____ _____ - _____ - _____
Name Date of Birth Social Security Number

_____ (___)_____
Mailing Address City, State Zip Home Phone

(___)_____ _____ (___)_____
Cell Phone Employer Work Phone

Marital Status: Single Married Divorced Separated

Mother

_____ _____/_____/_____ _____ - _____ - _____
Name Date of Birth Social Security Number

_____ (___)_____
Mailing Address City, State Zip Home Phone

(___)_____ _____ (___)_____
Cell Phone Employer Work Phone

Marital Status: Single Married Divorced Separated

Person(s) Caring for Child other than Biological Parents

_____ (___)_____ (___)_____
Name Home Phone Cell Phone

_____ (___)_____
Mailing Address City, State Zip Work Phone

If the child has any brothers or sisters please list, including ages. _____

Religious Background _____ Church Involvement: Active Moderate Inactive
Church Name

Counseling Experience Has child had previous counseling experience? Yes No _____
Name of Previous Counselor

Please list family history of substance abuse or mental health problems: _____

_____

Adverse Childhood Experience (ACE) Questionnaire

(Ages 0-8yrs form to be completed by parents)

While you were growing up, during your first 18 years of life:

1. **Did a parent or other adult in the household often …**
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____
2. **Did a parent or other adult in the household often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____
3. **Did an adult or person at least 5 years older than you ever…**
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____
4. **Did you often feel that …**
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____
5. **Did you often feel that …**
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____
6. **Were your parents ever separated or divorced?**
   Yes No If yes enter 1 _____
7. **Was your mother or stepmother:**
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____
8. **Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?**
   Yes No If yes enter 1 _____
9. **Was a household member depressed or mentally ill or did a household member attempt suicide?**
   Yes No If yes enter 1 _____
10. **Did a household member go to prison?**
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Child Social History

_____ _____/_____/_____
(Child's Name) (Date)

1) **What would you consider to be your child's major stressors?**___Break-Up with Girl/Boy Friend __Eating Disorder __Conflict Between Parents or With Parents___Housing___Physical Abuse__ Legal ___Conflict With Siblings__Violence in Home __Neglect__Death/Loss/Serious Illness of___Loved One ___Financial Concern___Sexual Abuse___Parent's Separation/Divorce__School __ Work Health/Physical ____Religious/SpiritualL____ No Current Stressors
2) **Which of the following problems do you feel the child needs help with?**___Feeling Sad or Down ___Issues Related to Past Abuse ___Very Nervous or Tense Relationship Problems ___Problems with Sleep___Very Fast Thoughts ___Unexplained, Frequent Mood Changes___Intense Anger/Aggressive ___Problems with Appetite___Discipline___Sexual Problems___Thoughts of Harming Self or Others ____Abusing Others___Difficulty with Memory, Concentration, or Decision Making___Problems at School ___Work Conflicts ___Reoccurring thoughts of Death___ Loss, Death, Divorce, Separation___ Eating Disorder/Body Image___Drug/Alcohol__Compulsive Behaviors___Religious /Spiritual__Hearing Voices or Seeing Strange Visions __Other_____
3) **Who has custody of the child?**__Both Parents __Mother__Father__Relative___DSS Other_____
4) Are natural parents married?___Yes ___No
5) Have there been previous marriages? __Yes ___No **If "yes,"** how many? Mother____ Father_____
6) If the child does not live with both natural parents does child see the parent that he/she does not live with? ___Yes ___No ___ Little Contact ____N/A
7) If parents are divorced or separated, what are the visitation arrangements?___Regularly Scheduled Visits ___Visit with Other Parent When Child/Parent Desires__ Inconsistent Visitation__No Visits or contact
8) Who lives in the child's household?___Both Parents___Father___Mother___Stepfather___Stepmother ____Foster Parents___Foster Children___Brothers/Sisters___Stepbrothers/Sisters___Half Brothers/Sisters ____Friend (s)___Relative (s)___Another Family___Pets Other_____
9) How many brothers or sisters does the child have, including step/half siblings?_____
10) How important are religious/spiritual practices to you?_Important _Very important__Unimportant __Neutral
11) What is father's education?_____ What is mother's education?_____
12) Has either parent had serious medical problems in the past six months?___Yes ___No
13) Has either parent had a history of mental health treatment?___Yes ___No
14) Has either parent been hospitalized for mental health problems?___Yes ___No
15) Is either parent taking medication for mental health reasons?___Yes ___No
16) Does either parent have current legal charges pending?___Yes ___No
17) Were there problems with pregnancy?___Yes ___No ___Do Not Know
18) Was the child delivered full term?___Yes ___No ___Do Not Know
19) Were there any immediate difficulties with the infant?___Yes ___No
20) Were there feeding problems?___Yes ___No
21) Was he/she more or less active compared to other children?_____
22) Was he/she well coordinated? ___Yes ___No
23) Were there any problems with speech development?___Yes ___No
24) Does the child wear glasses?___Yes ___No
25) Has the child received all of his/her current shots? ___Yes ___No
26) Is the Child receiving special education services? ___Yes ___No
27) Has the child been physically or sexually abused?___Yes ___No