



Parental Acknowledgment and Understanding of the Child Therapist's Role

Introduction:

We are committed to providing a supportive and nurturing environment for your child as they navigate through life's challenges. It is important to clearly define the role of our therapists to ensure a mutual understanding of our objectives and limitations.

Role of the Child Therapist:

- **Emotional and Psychological Support:** Our primary role is to offer emotional and psychological support to your child. We aim to help them express their feelings, develop coping strategies, and build resilience.
- **Therapeutic Environment:** We provide a safe and confidential space where your child can explore their thoughts and emotions without judgment.
- **Guidance Through Personal Challenges:** We assist your child in understanding and managing personal challenges, including those related to family changes, such as divorce.

Limitations of the Therapist's Role:

- **No Legal Advocacy:** Our therapists are not legal advocates and do not participate in custody disputes or provide testimony in court regarding custody matters.
- **No Custody Recommendations:** We do not make recommendations regarding custody or visitation arrangements. Our focus is solely on your child's well-being.
- **Non-Involvement in Legal Proceedings:** We do not engage in legal proceedings or communicate with legal representatives on behalf of either parent.

Guidance for Legal and Custody Issues:

- **Referral to Legal Professionals:** For matters related to custody, divorce, or legal advocacy, we recommend consulting with a guardian ad litem or other legal professionals who specialize in child advocacy.

Acknowledgment: By signing this document, you acknowledge that you have read and understood the role and limitations of our therapists. You agree to seek appropriate legal counsel for any custody or legal matters and understand that our focus is on supporting your child's emotional and psychological health.

Parent/Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Strong Sprouts Child Therapy Intake

Please complete on behalf of your child

Parent/Guardian Contact Information

1. Name of person completing this form:

Your relation to the child:

Phone:

Email:

2. Name of other parent/legal guardian:

Phone:

Email:

Child's Information

Child's first name:

Last name:

Age:

Birthdate:

Sex/Gender:

Ethnicity:

Religion:

Home address:

Person(s) your child lives with:

Biological child?

☐ Yes

☐ No

Adoption Year:

Foster since:

Academic Information

Name of child's school:

Grade/year:

Special Program or IEP, if applicable:

Typical grades:

Has child ever skipped a grade?

When?

Has child ever been held back a grade?

When?

Reason for child's visit & Concerns

How intense is your child's emotional distress?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)
 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Please describe

Overall, how much do the problems affect your child's ability to perform school, get along with others, and perform daily tasks such as chores?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)
 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Please describe

When did these problems start? What was going on in your child's life at that time?

Do you have concerns about any of the following? If so, for how long?

1. Physical

- ☐ ☐ Sleep problems
- ☐ ☐ Fatigue/low energy
- ☐ ☐ Appetite/weight changes
- ☐ ☐ Headaches/stomach aches

2. Attention

- ☐ ☐ Forgetful/memory problems
- ☐ ☐ Short attention span
- ☐ ☐ Can't sit still
- ☐ ☐ Concentration problems
- ☐

- ☐ ☐ Talks excessively/interrupts
- ☐ ☐ Easily distracted
- ☐ ☐ Impulsive
- ☐ ☐ Difficulty following rules
- ☐ ☐ Problems completing homework

3. Social

- ☐ ☐ Unassertive
- ☐ ☐ Withdrawal
- ☐ ☐ Not interested in peers
- ☐ ☐ Picked on/bullied by peers
- ☐ ☐ Aggressive behavior/bullies others

6. Behavior:

- ☐ ☐ School refusal
- ☐ ☐ Frequent tantrums
- ☐ ☐ Odd motor movements
- ☐ ☐ Hallucinations
- ☐ ☐ Odd beliefs/fantasizing

4. Anxiety

- ☐ ☐ Excessive worry/fearfulness
- ☐ ☐ Anxiety of panic attacks
- ☐ ☐ Social fears, shyness
- ☐ ☐ Separation problems
- ☐ ☐ Bedwetting/soiling
- ☐ ☐ Nightmares
- ☐ ☐ Resistance to change
- ☐ ☐ Perfectionism

7. Disruption:

- ☐ ☐ Lying
- ☐ ☐ Trouble with the law
- ☐ ☐ Running away
- ☐ ☐ Truancy, skipping school
- ☐ ☐ Hurting others physically/fighting
- ☐ ☐ Hurting others sexually
- ☐ ☐ Alcohol/drug use
- ☐ ☐ Argumentative/defiant
- ☐ ☐ Swears
- ☐ ☐ Blames others for mistakes
- ☐ ☐ Stealing
- ☐ ☐ Being destructive
- ☐ ☐ Fire setting
- ☐ ☐ Hurting animals
- ☐ ☐ Acts as if has no fear
- ☐ ☐ Short-tempered
- ☐ ☐ Easily annoyed/annoys others
- ☐ ☐ Angry and resentful

5. Mood:

- ☐ ☐ Morbid thoughts
- ☐ ☐ Suicidal thoughts or threats
- ☐ ☐ Suicide plans/attempts
- ☐ ☐ Mood swings
- ☐ ☐ Depression
- ☐ ☐ Changed level of activity
- ☐ ☐ Cries easily

Legal Information

Is this child currently involved in any of the following? (Check all that apply):

- ☐ Child Protective Services (CPS)
- ☐ Custody or divorce proceedings
- ☐ Court-ordered therapy or evaluations
- ☐ Restraining/protective orders
- ☐ Other legal matters
- ☐ None

If applicable, please describe:

Psychiatric and Medical History

Please list any psychiatric or “mental” problems your child has been diagnosed with:

Please list any medical or “physical” problems that your child has been diagnosed with:

Please list any medications your child currently takes, and what they are taken for:

Name of primary care physician:

Phone:

Last check-up was on:

Results of check-up:

Name of Psychiatrist:

Phone:

Last visit was on:

Results of session:

Mental Health Treatment History

Has your child ever been hospitalized for psychological or psychiatric reasons? ☐ No ☐ Yes

If yes, please describe when and where, and for which reasons.

Please tell me about any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

Current Habits

Please describe your child's current habits in each of the following areas:

Smoking:

Drinking:

Drug use:

TV use:

Internet use:

Video game use:

Caffeine intake:

Exercise:

Eating:

Sleeping:

Fun and relaxation:

Chores and responsibilities:

Relationships

Please describe your child's relationships with each of the following people, if applicable:

Biological Mother:

Biological Father:

Stepparents:

Legal guardians:

Siblings:

Extended family:

Friends:

Romantic partner(s):

Classmates:

Total number of close, supportive relationships:

Please list all members in the household:

Full name	Age	Sex/Gender	Relation (full, half, step, adoptive, etc.)

Stressful Life Events

Please describe any significant or stressful life events that your child has experienced:

Stressful Life Event	Yes	No	Describe
A recent move or change in school?	☐	☐	
Abuse or neglect?	☐	☐	
Bullied or ignored by peers?	☐	☐	
Academic difficulties?	☐	☐	
Weight control issues?	☐	☐	
Sexual orientation concerns?	☐	☐	
Gender identity concerns?	☐	☐	
Self-injury?	☐	☐	
Death or illness of a loved one or pet?	☐	☐	
Family conflict?	☐	☐	

Separation or Divorce?			☐	☐
Other?			☐	☐

Strengths

What are your child's positive qualities and skills?

What do you like about your child?

What qualities have helped your child to succeed at overcoming difficulties in the past?

Please tell us about your child's interests (sports, hobbies, talents, etc.)

Treatment Goals

Does your child agree that the problem that she or he is seeking help for is problematic?

What are some goals for your child's therapy?

What would you like them to achieve by attending therapy?

Additional Comments

[illegible]