

Child Intake History Form

Please fill out this form and send it back to TELL Counseling. This form contains a total of 6 pages. We provide the option to fill out the form below directly and send it back as an e-mail attachment to clinical.assist@telljp.com. However, be advised that we cannot guarantee the confidentiality of your information due to the insecure nature of internet forms of communication. If you send this file as an e-mail attachment, please do not fill in fields that make identification possible.

If you have any doubts about submitting this form online, you may print out the PDF version, fill it out by hand and send it back by fax to: 03-4550-1192 (Attention: Clinical Coordinator). In the event there is a waitlist to schedule an assessment, your priority will be based on the date this form is received. If you have any questions, please contact us at 03-4550-1146 (Mon-Fri, 10 am – 5:30 pm).

GENERAL INFORMATION & CONTACT INFORMATION

Child's Name: _____ M F
Date of Birth (mm/dd/yy): _____ **Age:** ____
Place (country) of birth: _____
Nationality(s): _____
Language(s) spoken: _____
Cell phone no: _____
Email: _____

Parent 1: _____ M F
Date of Birth: _____ **Age:** ____
Place (country) of birth: _____
Nationality(s): _____
Language(s) spoken: _____
Cell phone no: _____
Email: _____

Parent 2: _____ M F
Date of Birth: _____ **Age:** ____
Place (country) of birth: _____
Nationality(s): _____
Language(s) spoken: _____
Cell phone no: _____
Email: _____

Postal address and phone number of primary residence:
Full address: _____
 _____ **Post code:** ____ - ____
Phone #: _____ **Fax #:** _____

Whose number can be used in case of emergency?
 Home Cell: _____ Alternate, i.e.: _____

Preferred intake appointment time/date:

ADDITIONAL INFORMATION

- What health insurance coverage do you/your family have? Japanese national health insurance
 CIGNA International*
 HTH Worldwide** GeoBlue**
 Private health insurance: _____
 Company EAP: _____
 No insurance Other: _____
- *Please bring your Member Card in your first session.
 ** Please contact the insurance company prior to counseling for guarantee of payment.
- Date (month and year) family/child arrived in Japan (if applicable): _____
- In how many countries did the child live? (Including Japan): ____
- Family's status of stay in Japan:
 Home country Second home country
 Foreign assignment Diplomatic
 Long-term/permanent resident
 Other: _____
- How long do you estimate staying in Japan? (in years)
 <1 1-5 6-10
 >10 undecided
- What are the most likely future plans in terms where to live? continue living in Japan

- back to home country
- live temporarily in a different country
- other: _____
- How did you get to know about TELL?
 School/University Friends/Family
 Physician/Hospital Clergy/Church
 Legal/Government Company /EAP
 Media/ads Other therapist
 Internet Search Engine: _____
 Other: _____
- Who referred you to TELL Children and Families?
 Yourself School/University
 Friends/Family Life Line
 Other therapist Physician/Hospital
 Company /EAP Insurance Agency
 Other: _____
- Do you allow TELL to contact the current school to get more information about your child?
 Yes No
- Do you allow us to put you on the mailing list for activities/lectures of the TELL Exceptional Parenting Program? Yes No

REFERRAL INFORMATION

Please list your main reason to contact TELL and/or any concerns about your child's learning, development and behavior:

Why have you sought help, at this time, for your child? _____

What do you hope your child will gain from the assessment / therapy? _____

FAMILY INFORMATION

- Is the child living with both biological parents?
 Yes No, namely: _____
 Adopted at age: _____
- Special circumstances or adoption information:

- Are both parents aware that you are seeking psychological services for your child? Yes
 No, because: _____
- If parents are living apart, divorced, or separated: Is the other parent aware that you are seeking psychological services for your child? Yes
 No, because: _____
- Do all siblings (biological or non-biological) live with the child? Yes No
- Please list other parent or guardian's information:

- If divorced, who has custody over the child?
 _____ has full custody
 parents have shared custody
 otherwise: _____

Occupation of **Parent 1**: _____

- Employment status:
 full-time employee part-time employee
 Name of company: _____
 unemployed self-employed
 home-care retired
 other: _____
- Highest level of education: Elementary school
 Middle school High school
 Vocational school Bachelor's
 Master's PhD
 Other: _____
- Age at time of marriage (if applicable): _____
- Age at time of divorce (if applicable): _____
- Previously married? Yes No
- Are there children from a previous relationship/ marriage? Yes No

Occupation of **Parent 2**: _____

- Employment status:
 full-time employee part-time employee
 Name of company: _____
 unemployed self-employed
 home-care retired
 other: _____
- Highest level of education: Elementary school
 Middle school High school
 Vocational school Bachelor's
 Master's PhD
 Other: _____
- Age at time of marriage (if applicable): _____
- Age at time of divorce (if applicable): _____
- Previously married? Yes No
- Are there children from a previous relationship/ marriage? Yes No

Siblings

1. Name: _____ M F
 Age: _____ Living at home? Yes No
 School/ Occupation: _____
 Relevant issues with this sibling: _____
2. Name: _____ M F
 Age: _____ Living at home? Yes No
 School/ Occupation: _____
 Relevant issues with this sibling: _____
3. Name: _____ M F
 Age: _____ Living at home? Yes No
 School/ Occupation: _____
 Relevant issues with this sibling: _____

*If child has more than 3 siblings, please provide details in the additional space at the end of this form.

Other Persons in the Home (e.g. au-pair, grandparents, nanny, extended family members etc).

1. Name: _____ M F
 Age: _____ School/ Occupation: _____
 Remarks: _____
2. Name: _____ M F
 Age: _____ School/ Occupation: _____
 Remarks: _____

How does your child get along with:

Parent 1? _____ Sister(s)? _____
 Parent 2? _____ Brother(s)? _____
 If applicable, relationship with parent’s significant others, half siblings, step-parent(s) or live-in grandparents: _____

What language(s) does the child speak with:

Parent 1? _____ Sister(s)? _____
 Parent 2? _____ Brother(s)? _____
 Other persons in the house (please be as complete as possible especially if the child speaks multiple languages to one person): _____

PREGNANCY/BIRTH HISTORY

- Biological mother’s health during pregnancy: (Check all that applied)

<input type="checkbox"/> Anemia /poor diet	<input type="checkbox"/> Weight problems
<input type="checkbox"/> Medication taken	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Toxemia	<input type="checkbox"/> HIV positive
<input type="checkbox"/> Urine problems	<input type="checkbox"/> Disease (identify)
<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Blood pressure
<input type="checkbox"/> Headaches	<input type="checkbox"/> Accidents
<input type="checkbox"/> Unusual physical strain	
<input type="checkbox"/> Unusual emotional strain	
<input type="checkbox"/> Other, specify: _____	
- Biological mother’s age at delivery: _____
- Please describe the biological mother’s pregnancy (in terms of complications, and emotional state):

- Child’s health issues during pregnancy? No
 Yes, namely: _____
- Describe your child’s health during and after delivery:

- Length of pregnancy (weeks): _____
- Length of active labor (hours): _____
- Was infant premature? No
 Yes, namely: _____
- Type of delivery: Spontaneous Forceps
 Caesarean Other: _____
- Position: head first feet first breech

- Did biological mother receive any medication during pregnancy? No Yes, namely: _____
 - Did biological mother smoke during pregnancy?
 No Yes, how much? _____
 - Did biological mother consume alcohol during pregnancy? No Yes, how much? _____
 - Did the infant require any interventions (e.g. oxygen supply, blood transfusion, x-rays, EEG, incubator) etc.? No Yes, namely: _____
 - As a baby, was your child breast-fed? No
 Yes, how long? _____
 - Any relevant issues while breastfeeding? No
 Yes, specify: _____
 - Check the items that apply to your child’s behavior when s/he was an infant:

<input type="checkbox"/> Frequently smiled	<input type="checkbox"/> Frequently cried
<input type="checkbox"/> Easy to soothe	<input type="checkbox"/> Difficult to soothe
<input type="checkbox"/> Difficulty with novelty	<input type="checkbox"/> Enjoyed being held
<input type="checkbox"/> Enjoyed being rocked	<input type="checkbox"/> Cried when wet
<input type="checkbox"/> Adapted easily to new situations	
- To the best of your knowledge please record the age (in months) at which the child accomplished each of the following: Sat alone: __ Stood alone: __
 Crawled: __ Walked alone: __
 Toilet trained (during day): __
 Said first word: __ (what word? _____)
 Used 2-3 word sentences: __ Rode a bicycle: __

CHILD’S HEALTH

- Name of child’s Primary Care Physician (PCP) or pediatrician: _____
 Name of organization: _____
- Current weight: ____ kg height: ____ cm
- For girl, date of last menstruation: _____
- Date of last medical checkup/doctor visit(s)? _____
 What were the findings? _____
- For children who have gone through the Japanese health services: Where there any relevant findings of the health check at 18 months and / or the health check at 3 years? NA No Yes
- What is your child’s present physical health? Please explain: _____
- Does the child take medication at this time? No
 Yes, specify : _____

- Did your child ever take medication for a longer period of time? (more than 3 weeks). No
 Yes, namely: _____
- Does your child have allergies? No
 Yes, specify: _____
- Is there a history of ear infections? No
 Yes, specify: _____
- Has your child’s hearing been tested? No
 Yes, specify: _____
- Has your child’s vision been tested? No
 Yes, (when) and findings were: _____
- Has your child’s blood been tested? No
 Yes, (when) and findings were: _____
- Has there ever been genetic testing of your child?
 No Yes, why and what were the findings:

- Has your child been exposed to toxic substances or heavy metals? No Yes
- Has your child patches of pigment on the skin (café-au-lait spots) /skin problems? No Yes
- Has your child ever:
 - been hospitalized/undergone surgery? No Yes
 - had any head injuries (e.g. due to falls, accidents etc.)? No Yes
 - lost consciousness? No Yes
 - had any seizures (epilepsy, or when having fever) ? No Yes
 - had eating problems? No Yes
 - had sleeping problems? No Yes
- Other current or previous medical issues? No Yes, specify: _____
- Has your child had a psychological /educational/ behavioral or language assessment before? No Yes (If yes, please bring the assessment report)

- Is there a history or current concern with any of the following? (Check all that apply/ applied):

<input type="checkbox"/> Head banging	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Nail biting	<input type="checkbox"/> Colic
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Wetting pants
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Speech difficulties
<input type="checkbox"/> Sadness	<input type="checkbox"/> Thumb sucking
<input type="checkbox"/> Teeth grinding	<input type="checkbox"/> (body) balance
<input type="checkbox"/> Soiling pants	<input type="checkbox"/> Temper tantrums
<input type="checkbox"/> Lying	<input type="checkbox"/> Self-harm / Suicide
<input type="checkbox"/> Fire setting	<input type="checkbox"/> Masturbation
<input type="checkbox"/> Headaches	<input type="checkbox"/> Coordination
<input type="checkbox"/> Oversensitive to sounds	<input type="checkbox"/> Sensory problems
<input type="checkbox"/> Emotional immaturity	<input type="checkbox"/> Drug/alcohol use
<input type="checkbox"/> Tics (involuntary movements)	
<input type="checkbox"/> Difficulty making friends	

SOCIAL AND EMOTIONAL INFORMATION

- List your child’s major interest and hobbies: _____
- Is your child involved in extracurricular activities? No Yes, namely: _____
- Friends (how many) Male: _____ Age range: _____ Female: _____ Age range: _____
- When interacting with peers, your child can be described as: _____
- Do you feel your child is having difficulties at home? No Yes
- Describe what you do consider the problem to be and when and how did it begin? _____

- Are there any past or present problems that could be related to your child’s difficulties? _____

- What are your child strengths? _____
- Has your child ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.?) No Yes
- Is there a history of physical or sexual abuse / (family) violence or neglect? No Yes
- Has your child ever:
 - received previous counseling from other individual /mental health organizations? No Yes
 - had any legal involvement? No Yes
 - been hospitalized for mental, behavioral or emotional problems? No Yes
 - had difficulty in focus/concentration? No Yes
 - had difficulty in remembering things? No Yes
 - ever been aggressive to peers, adults, animals, property, or self? No Yes
 - ever been inappropriately sexual towards peers, adults, animals, or self? No Yes
 - ever been bullied? No Yes
- Did someone in the child’s family (sibling, parent, aunt/uncle, grandparent etc.) have:
 - an emotional or psychiatric problem? No Yes
 - a learning problem (e.g. in reading, math, etc.)? No Yes
 - an attention problem? No Yes
 - a behavioral problem? No Yes
- How are you doing as a parent(s) at this moment? (E.g. Are there any parental or marital issues that you are struggling with?) No Yes
- Are there possible stressors in the current living situation (financial, space, unemployment risk) that worry you and/or that could affect the child? No Yes

FOR ADOLESCENTS

What physical changes have you noticed? _____

- Have you noticed a change in your child’s attitude towards (check all applicable):
 School Family Friends
 Recreation Eating
 Other activities? Please explain: _____

- How many hours does your child/teenager spend on the internet each day (e.g. gaming, social networking sites)? _____
- Do you have concerns about the type of material they may be accessing (e.g. violent, or sexually explicit material)? No Yes, specify: _____

- Drinking history (if applicable):
 Age of first alcoholic drink: ____
 Age of first intoxication: ____
 Age of recognition of problem: ____
 Drink preference: _____
 Quantity: _____ Frequency: _____
- Drug history (if applicable):
 Name of drug: _____
 Age first used: ____
 Age of recognition of problem: ____
 Quantity: _____ Frequency: _____

EDUCATIONAL INFORMATION - List all schools your child has attended (include nursery and day care if applicable)

*****Do not forget the current school and grade*****

Nursery/ Day care

Name	City	Grade(s):	Age of child:	Reason for leaving:	Language of instruction:

Kindergarten/Preschool

Name	City	Grade(s):	Age of child:	Reason for leaving:	Language of instruction:

Elementary/primary School

Name	City	Grade(s):	Age of child:	Reason for leaving:	Language of instruction:

Secondary/ High School

Name	City	Grade(s):	Age of child:	Reason for leaving:	Language of instruction:

- Has your child ever repeated or skipped a grade?
 No Yes, explain: _____

- Is your child having any learning problems at school?
 No Yes, explain: _____

- Is your child having any other problems at school?
 No Yes, explain: _____

- Has your child ever been suspended from school?
 No Yes, explain: _____

- Has your child ever been expelled? No Yes, explain: _____

- Is your child in special classes or does/did he/she have learning support? No Yes, namely for: _____

- In what grade(s): _____
- Does your child attend(ed) English as a Second Language classes (ESL)? No
 Yes, specify (where, when, how long): _____

- What kind of grades does your child usually earn? (please bring recent report cards): _____

- In what classes or school situations does your child usually perform the best? _____

- Has your child ever been diagnosed with a specific learning disability? No Yes, namely: _____

Please list any other (not yet mentioned) concerns about your child’s learning, development and behavior:

Signature of person filling out this form: _____ Date: _____

Relationship to child: mother father other: _____

****Thank you for your cooperation****