tell Counseling

Ver. 5.13

Child Intake History Form

Please fill out this form and send it to 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

TELL Counseling
English: 03-4550-1146 Japanese: 03-4550-1147 Fax: 03-4550-1192
Wesley Center 2F, 6-10-11 Minami-Aoyama, Minato-ku, Tokyo 107-0062 www.telljp.com

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)
  ☐ Anemia /poor diet ☐ Weight problems
  ☐ Medication taken ☐ Bleeding
  ☐ Toxemia ☐ HIV positive
  ☐ Urine problems ☐ Disease (identify)
  ☐ Nausea/vomiting ☐ Blood pressure
  ☐ Headaches ☐ Accidents
  ☐ Unusual physical strain
  ☐ Unusual emotional strain
  ☐ 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:
  ☐ Frequently smiled ☐ Frequently cried
  ☐ Easy to soothe ☐ Difficult to soothe
  ☐ Difficulty with novelty ☐ Enjoyed being held
  ☐ Enjoyed being rocked ☐ Cried when wet
  ☐ 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):

☐ Head banging	☐ Bed wetting
☐ Nail biting	☐ Colic
☐ Vomiting	☐ Wetting pants
☐ Anxiety	☐ Speech difficulties
☐ Sadness	☐ Thumb sucking
☐ Teeth grinding	☐ (body) balance
☐ Soiling pants	☐ Temper tantrums
☐ Lying	☐ Self-harm / Suicide
☐ Fire setting	☐ Masturbation
☐ Headaches	☐ Coordination
☐ Oversensitive to sounds	☐ Sensory problems
☐ Emotional immaturity	☐ Drug/alcohol use
☐ Tics (involuntary movements)	
☐ 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:
  _____
  _____

P**lease 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