**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 (this is a fillable form) 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 – 6 pm).

**Parents’ Appointment Availability:**      ,  AM  PM

**GENERAL INFORMATION & CONTACT INFORMATION**

**Child’s Full** Name:        M  F

Date of Birth:       **Age:**

Place (country) of birth:

Nationality(s):

Language(s) spoken:

Cell phone no:

Email:

**Name of Parent 1**:   M  F

Date of Birth: **Age:**

Place (country) of birth:

Nationality(s):

Language(s) spoken:

Cell phone no:

Email:

**Name of 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:      -

Home phone #:      Home fax #:

Which number can be used in case of emergency?

Home  Cell:   Alternate, i.e.:

**ADDITIONAL INFORMATION**

* What private health insurance coverage do you/your family have?

CIGNA International\*  Tricare\*\*

HTH Worldwide\*\*  GeoBlue\*\*

Other:

Company EAP:

No insurance

*\*Please bring your Member Card in your first session.*

*\*\*Please contact your insurance company directly to obtain the following information about your coverage.*

My plan is , under the policy name of

My plan has a deductible of $/€/£/¥

I have met $/€/£/¥ as of today.

I agree to pay full fee until my deductible is met and then I will pay my full co-pay at each session. If there is no deductible I will pay my full co-payment.

My plan pays % of the full fee, or ¥ . My co-pay is % of the full fee, or ¥ .

My plan has a yearly limitation of $/€/£/¥  and/or visits .

My plan requires pre-approval of sessions or it will not reimburse.

I agree to pay full fee if my plan does not pay TELL Counseling.

My plan is an EAP and provides brief treatment. If I need more lengthy therapy, I understand that I may be self-referred or have to be referred out.

Other

* 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  Lifeline

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 TELL 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:

1. Name:       M  F

Age:  Living at home?  Yes  No

School/ Occupation:

Relevant issues with this sibling:

1. 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:

1. 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 or 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 or 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:** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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**Kindergarten/Preschool**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **City** | **Grade(s):** | **Age of child:** | **Reason for leaving:** | **Language of instruction:** |
|  |  |  |  |  |  |
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**Elementary/primary School**

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

**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(e**d) 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\*\*