Thomas Deshler Ph.D. P.C.
Willamette Valley Family Center, LLC
610 Jefferson Street - Oregon City, Oregon 97045 ---- (503) 657-7235

CHILD INTAKE EVAULATION - (To be completed by the parent or guardian)

1. IDENTIFYING INFORMATION

Child's Name: _____ Today's Date: _____ Referred By: _____

Gender: M ☐ F ☐ Age: _____ Birth Date: _____ (mm/dd/yyyy) Social Security (ID) #: _____

Custodial Parent Name: _____

Home address: _____
Street City State Zip

Telephone: _____
(home) mother (work) father (work)

May we leave messages for your at home? Yes ☐ No ☐ May we leave messages for your at work? Yes ☐ No ☐

School Child Attends: _____ Grade in School: _____ Phone: _____

Others living in the home: _____ _____
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

_____ _____ _____
(name, birthdate, relationship to client) (name, birthdate, relationship to client) (name, birthdate, relationship to client

Immediate family living outside the home: _____ _____
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

Emergency contact: _____ Phone: _____

Insurance Information

Name of insured: _____ Insured date of birth: _____ (mm/dd/yyyy)

Address of insured person: _____
Street City State Zip

Relationship of client to insured person: _____

Insurance Company: _____ Phone: _____

Insurance Company Address: _____
Street City State Zip

Insurance Identification Number: _____ Group Number: _____

Employer of insured person: _____

Secondary insurance: _____ Phone: _____

Name of secondary insured: _____ Date of Birth: _____ (mm/dd/yyyy)

Secondary company address: _____
Street City State Zip

Secondary identification number: _____ Group number: _____

Employer on secondary insurance: _____

PATIENT OR AUTHORIZED PERON'S SIGNATURE: I authorizer the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provide of services

_____
Signature (Insured) Date

Child's Name: _____

2. PRESENTING PROBLEM

Describe the child's problem (s) that brought you here today:

Check any of the symptoms that the child has been having:				(This space reserved for additional comments by clinician)
Depressed mood		Feels hopeless		
Extreme sadness		Tearful/crying spells		
Trouble concentrating		Memory problems		
Change in sleeping habits		Lack of energy		
Security blanket or object		Stuttering		
Bedwetting		Thumb sucking		
Change in eating habits		Weight/appetite changes		
Problems getting along with family		Problems getting along with friends		
Doesn't seem to enjoy usual activities		Feeling of extreme happiness		
Trouble doing school work		Truancy		
Feeling stressed		Irritability		
Low self-esteem		Isolation/withdrawal		
Perfectionistic		Expressed feeling of guilt		
Worries		Seems nervous		
Feeling fearful		Sudden feelings of panic		
Physical complaints of pain		Tense/uptight		
Anger outbursts		Acting violently		
Running away		Harm to animals		
Has hurt or cut on themselves		Fire setting		
Thoughts of killing self		Thoughts of killing others		

Continue on other side

3. WHAT HAS BEEN DONE ABOUT THIS PROBLEM SO FAR?

Have you worked with the child's teacher or school counselor? **Yes** ☐ **No** ☐

If you have, please describe it below

Name of teacher or counselor:	Date (s):

Has this child been in counseling before? **Yes** ☐ **No** ☐

If the child has been in counseling before, please describe it below, starting with the most recent first.

A. When was the counseling?	Date (s):
Who did you see?	Name:
Explain what happened:	
B. When was the counseling?	Date (s):
Who did you see?	Name:
Explain what happened:	

Has the child been prescribed any psychiatric medications? **Yes** ☐ **No** ☐

If yes, please describe:	Date (s):

4. SUSTANCE USE HISTORY (If Applicable)

Does the child use tobacco (any form?)	Current ☐	Suspected ☐	Past ☐	No ☐
Does the child use alcohol?	Current ☐	Suspected ☐	Past ☐	No ☐
Does the child use caffeine (any form including cola drinks)?	Current ☐	Suspected ☐	Past ☐	No ☐
Does the child use recreational drugs?	Current ☐	Suspected ☐	Past ☐	No ☐

Continue on next page

Child's Name:_____

5. MEDICAL INFORMATION

Has the child seen a doctor within the last year?	Yes ☐	No ☐
What was that for?		
Who is the child's doctor? Phone:		
Is the child taking any medications (prescription or over –the counter)?	Yes ☐	No ☐
Please list any medications that the child is taking:		
Please list any major medical problems that the child has had such a chronic illness, serious illness, operations, injuries or trauma to the head, etc.:		
Does the child have allergies to anything?	Yes ☐	No ☐
Describe any allergy problems that he or she may have:		
Does the child have problems with sleeping?	Yes ☐	No ☐
Does the child have any problems with eating?	Yes ☐	No ☐
Does the child have any problems with toileting ?	Yes ☐	No ☐
Describe the problem(s):		
Has the child been affected by any issues such as witnessing violence, having accidents, experiencing loss or experiencing abuse (physical, sexual or emotional). Please describe the relevant issue(s):	Yes ☐	No ☐

Continue on other side

6. DEVELOPMENTAL HISTORY

Were there any problems with the pregnancy or the delivery of the child?	Yes ☐	No ☐
Any problems with eating, sleeping or crying spells, colic, nightmares, etc.?	Yes ☐	No ☐
Did the child demonstrate any difficulties or delays in walking, talking, and toilet training?	Yes ☐	No ☐
Has there been any family crisis such as marital separation or divorce?	Yes ☐	No ☐
Have there been any mental health problems in the family of origin?	Yes ☐	No ☐
Have there been any substance use or abuse issues in the family?	Yes ☐	No ☐
Briefly describe the child's relationship to parents:		
Briefly describe the child's relationship to siblings:		
Briefly describe the child's temperament:		

7. SCHOOL HISTORY

When did the child start school?		
Were there any problems when the child started school?	Yes ☐	No ☐
What problems have come up during the school years?		
What grades is the child getting?		
Describe any changes in the child's school performance:		
How does the child get along with his or her teachers?		
How does the child get along with his or her friends or peers in school?		
What are the child's favorite subjects or school activities?		
What subjects or activities does the child have problems with?		