Clinical Psychologists
Jénine Smith Inc.

Auckland Practice
9 Claremont Way, East Tāmaki Heights, Auckland

Intake Form For Children

Details of Child/Adolescent

Full Name:_____

Date Of Birth:_____

Current Age:_____

Contact Number:_____

Residential Address:_____

Current Grade:_____

Gender ☐ Male ☐ Female ☐ Other

Details of Parent 1

Full Name: _____

Relation to Child:_____

Occupation:_____

Contact Number: _____

Residential Address: _____

Working Hours:_____

Personal Psychiatric History:_____

Main Concern/ Reason for seeking therapy:_____

Details of Parent 2

Full Name: _____

Relation to Child: _____

Occupation: _____

Contact Number: _____

Residential Address: _____

Working Hours:_____

Personal Psychiatric History:_____

Main Concern/ Reason for seeking therapy:_____

Sibling 1

Full Name: _____

Current Age: _____

Psychiatric History:_____

Current Grade: _____

Gender Male___ Female___ Other___

Sibling 2

Full Name: _____

Current Age: _____

Psychiatric History: _____

Current Grade: _____

Gender Male___ Female___ Other___

Sibling 3

Full Name: _____

Current Age: _____

Psychiatric History: _____

Current Grade: _____

Gender Male___ Female___ Other___

Details of any other individuals in within the household:

Full Name: _____

Current Age: _____

Relation:_____

Please provide an overview of the child's weekly routine including where the child resides (if separation or divorce), social/leisure activities, extra murals and studying:

_____

_____

_____

_____

Please indicate either child's history or family history of any of the following conditions: (Learning Disabilities, Mood disorders, Substance abuse, Anxiety disorders, Trauma/stressor related disorders, Suicide attempts, Eating disorders, Attention Deficit Hyperactivity disorders, Other behavioural problems)

_____

_____

_____

_____

Please provide any relevant details regarding child/adolescent psychiatric history including dates and treatment sought:

_____

_____

_____

_____

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NZPB Registration Number:90-07822

Please indicate any other medical conditions the child/adolescent has been diagnosed with:

_____

_____

_____

_____

Early Development

Please provide any details regarding pregnancy (term/complications/hospitalisation/substance abuse etc.):

_____

_____

_____

_____

Please provide any details regarding the first year of life (feeding or sleeping problems/milestones/any significant separation from caregivers):

_____

_____

_____

_____

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Schooling:

Current School:_____
History of schools (including any changes of schools and dates)

_____

General academic performance:_____

Current academic performance:_____

Behaviour at school: _____

Trauma:

Please list any traumatic events which may have occurred including dates (e.g., exposure to violence, natural disasters, death of a friend/family/pet)

_____

_____

_____

_____

Strengths:

Please list the qualities you feel are strengths of the child/adolescent:

_____

_____

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Please describe the family's view on religion and how it impacts on the child/adolescent:

_____

_____

In order to provide the best possible standard of care to your child/adolescent we require detailed information across the contexts your child functions in (home/school/social) please provide us with any reports or additional information you may believe can be relevant for the psychologist to be aware of.

_____

_____

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