JÉNINE SMITH INC.
clinical psychologists
HPCSA No. 0119822 I Practice No. 0527823

**PLATTEKLOOF PRACTICE:**
58 Keurboom Crescent, Plattekloof 2, Parow, 7500
**CLAREMONT PRACTICE:**
253 Main Road, Claremont, 7708
**ROSENPARK PRACTICE PRACTICE:**
Block A, Ground Floor, Belvedere Office Park, Pasita Road, Rosenpark, 7550

# 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:

_____

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## 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:

_____

## Siblings:

## Sibling 1

Full Name: _____

Current Age: _____

Psychiatric History: _____

Current Grade: _____

Gender □ Male □ Female □ Other

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**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: _____

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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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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)

_____

_____

_____

_____

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**Strengths:**

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

_____

_____

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.

_____

_____