

# Child Intake Questionnaire

## TriHealth EAP

(Please Print)

**Child's name** \_\_\_\_\_ **Date of birth** \_\_\_\_\_

Parent (s') names \_\_\_\_\_

What company is your EAP benefit through? \_\_\_\_\_

What brings your child to counseling?

\_\_\_\_\_  
\_\_\_\_\_

What are the goals for counseling?

\_\_\_\_\_  
\_\_\_\_\_

### FAMILY

#### People Living in Your Household:

Name	Age	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

#### List sibling(s) not currently living in the household:

Name	Age	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Who has custody of your child?**

- Birth parents                                       Father only                                       Mother only                                       Joint custody
- Other, please explain \_\_\_\_\_

**Is your child experiencing any problems in relationships with: (check all that apply)**

- Childcare providers/ teachers     Father                                       Mother                                       Step-parent
- Siblings                                       Step-siblings                                       Friends                                       None
- Other, please explain \_\_\_\_\_

**EDUCATION**

School your child attends \_\_\_\_\_

Grade \_\_\_\_\_

Please explain any school related issues, such as attendance, peer relationships, academic issues, or behavior.

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**HEALTH HISTORY**

Primary Care Physician/ Pediatrician \_\_\_\_\_

Date of last visit to doctor \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

- Trouble sleeping                                       Yes                                       No
- Change in appetite in the last month                                       Yes                                       No
- Use of tobacco, e-cigarettes or vape                                       Yes                                       No

Please explain any issues with eating/ nutrition, sleeping or use of tobacco products.

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Does your child have any significant medical conditions?

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List the specialists' they see \_\_\_\_\_

Medications your child currently takes

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Please describe any concerns with your child's sexual activity or development.

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**BEHAVIORAL HEALTH**

Has your child had previous counseling  Yes  No  
Been in alcohol or drug treatment  Yes  No

If yes, please provide the name of the therapist and/ or treatment program. When?

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**Has your child: (check all that apply)**

Talked about suicide  Yes  No Threatened physical harm  Yes  No  
Attempted suicide  Yes  No Harmed a pet or small animal  Yes  No  
Cut or mutilated their body  Yes  No Run away from home  Yes  No

If yes, please describe.

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**Has your child witnessed or experienced: (check all that apply)**

Emotional abuse  Yes  No Domestic violence  Yes  No  
Physical abuse  Yes  No Other significant trauma  Yes  No  
Sexual abuse  Yes  No

If yes, please explain.

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**In daily activities, does your child find it difficult to: (check all that apply)**

Adapt to change  Yes  No Follow directions  Yes  No  
Problem solve  Yes  No Perform good hygiene  Yes  No  
Make decisions  Yes  No Focus on a task  Yes  No

If yes, please describe.

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**What has occurred recently in your child's life: (check all that apply)**

Death in the family  Yes  No Divorce or separation  Yes  No  
Move to a new location  Yes  No Frightening experience  Yes  No  
Significant trauma  Yes  No

Serious illness or injury to family member or friend  Yes  No

If yes, please describe.

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**ALCOHOL AND DRUG HISTORY**

Describe what you know about your child's alcohol and drug use.

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- Have others expressed concern about your child's alcohol or drug use  Yes  No
- Has your child been in legal trouble due to alcohol or drug use  Yes  No
- Have any family members had difficulty with alcohol or drugs  Yes  No

**With alcohol and drug use, have you recently noticed in your child:**

- |                       |                              |                             |                               |                              |                             |
|-----------------------|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|
| Change in peers       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mood swings                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Relationship problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emotional issues              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| School issues         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stealing from family/ friends | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Work problems         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Increased frequency/ quantity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**LEGAL ISSUES**

- Has your child had involvement with the legal system  Yes  No
- Any legal problems with other family members  Yes  No
- Please explain

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**CULTURAL AND SPIRITUAL ISSUES**

What are the cultural, ethnic, and racial issues that need special consideration?

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What are the religious and spiritual issues for consideration?

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Is there anything else your counselor should know about your child?

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\_\_\_\_\_  
Custodial Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed/Updated by Clinician

\_\_\_\_\_  
Date

## Statement of Understanding Client's Rights and Responsibilities

### TriHealth EAP

**What does TriHealth EAP provide?**

TriHealth EAP provides counseling services at no cost to you. Specifically, TriHealth EAP provides assessment, short-term counseling when appropriate, referral when needed, and follow-up. When a problem requires specialized or longer-term services, a referral will be made following the assessment of your situation. If you are referred, there may be fees involved for the specialized or long-term services. Those services may be covered under the medical benefits plan provided by your employer; however, it is your responsibility to determine whether the services are covered by the plan.

**What does a referral involve?**

When a referral is advised, your counselor will work with you to find an appropriate resource. We find it is in your best interest to make the referral at the earliest possible point so you can start working immediately with the appropriate treatment provider. The referral usually takes place after the first or second session with the TriHealth EAP counselor.

**Is TriHealth EAP counseling confidential?**

No information regarding you or your problem can be released to anyone without your express written consent. If you request we contact someone on your behalf, you must complete an informed consent release. State and federal laws, however, mandate in cases of child abuse, elderly abuse, or when a person may be a threat to their own or someone else's safety, the counselor must notify the proper authorities. TriHealth EAP must also release records if ordered to do so by a court of law. TriHealth EAP complies with State and Federal Law including CFR42 and the Health Information Portability and Accountability Act (HIPAA).

**What are the counselor's responsibilities?**

Your counselor is responsible for defining the problems as fully as possible. This process is started by completing a general history. Through this assessment, the counselor will determine an approach to the problem, be it short-term counseling or a referral. Your counselor will provide you with honest information about the nature of your particular problems and recommend treatment alternatives based on what is most likely the best outcome. The final decision on what to do is up to you.

**What are your responsibilities?**

The counseling process is most likely to produce results if you are willing to look at your own behavior, are honest, and are willing to act on what is learned in counseling. You are responsible for setting and keeping appointments.

**Please provide as much notice as possible if an appointment is going to be missed.**

Any appointment not properly cancelled will be considered a "no show" and will be counted towards your EAP benefit. Generally, failure to notify is considered lack of involvement in the counseling process.

Our goal is a positive, helpful experience for you at TriHealth EAP. Feel free to discuss any problems or concerns you have with the counselor or to call 513 891 1627 or 1 800 642 9794. We value your confidence in us and your suggestions to improve our services.

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Client Signature

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Date

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Client Name (Please Print)

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Reviewed/Updated by Clinician

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Date

## Notice of Privacy Practices

### TriHealth EAP

I, \_\_\_\_\_ (Print Your Name) hereby  
acknowledge that I have received the Notice of Privacy Practices from TriHealth EAP.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

(This acknowledgement form will be scanned into the clinical chart)

## Consent to Treat a Minor

### TriHealth EAP

I \_\_\_\_\_ custodial parent/legal guardian of  
\_\_\_\_\_, Age \_\_\_\_\_,

authorizes TriHealth EAP to assess and treat my child in an outpatient counseling setting.

I agree to take part in the counseling process as needed, and understand the format of counseling may include any combination of the following: individual sessions with minor child, family sessions, and sessions with the parent(s)/guardian(s).

\_\_\_\_\_  
Custodial Parent /Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship