Dr. Meena Gnanasekharan, MD, DABPN
American Board Certified in Child, Adolescent and Adult Psychiatry
Consultant Psychiatrist
KMC Regn. No. 92604

ReACH
PSYCHIATRY

Child Intake Form

Name: _____ Date: _____ Age: _____ Grade: _____

Address: _____

Phone: _____ Gender: ___M ___F Date of Birth: _____

Primary reason for seeking counseling:

_____

_____

_____

_____

Family History

Parents

Parents are / were married ____ years.

Are parents divorced? ____Yes ____No if yes, how old was the child at time of divorce: _____

Are parents married? ____Yes ____No if no, which has legal custody: _____

ReACH Psychiatry & Wellness Centre

#601, 3rd Cross, Opp: St Jude Church, HMT Layout, Ganganagar, Bangalore -560032. Ph.: 23637373
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FOR TELECONSULTATION VISIT www.reachpsych.com

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Is there any significant information about the parents' relationship or treatment towards the child which might be beneficial in counseling: ____Yes ____No?

If yes, explain: _____

_____

Client's Mother (Step-mother)

Name: _____ Age: ____ Work phone: _____

___Natural parent ___Step-parent ___Adoptive parent ___Foster parent other: _____

Is there anything unusual or stressful about the child's relationship with the mother? ____Yes ____No

If yes, explain: _____

Client's Father (Step-father)

Name: _____ Age: ____ Work phone: _____

___Natural parent ___Step-parent ___Adoptive parent ___Foster parent other: _____

Is there anything unusual or stressful about the child's relationship with the father? ____Yes ____No

If yes, explain: _____

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Siblings and Others in Household

Names of Siblings	Age	Gender		Lives		Quality of Relationship w/ Client		
		M	F	Home	Away	Poor	Average	Good
_____	___	___	___	___	___	_____	_____	_____
_____	___	___	___	___	___	_____	_____	_____
_____	___	___	___	___	___	_____	_____	_____
_____	___	___	___	___	___	_____	_____	_____

Others living in household				Relationship to child			
_____	___	___	___	_____	_____	_____	_____
_____	___	___	___	_____	_____	_____	_____
_____	___	___	___	_____	_____	_____	_____

Medical

List any medication your child is on: _____

_____

List any medical conditions the child has been diagnosed with and / or any surgeries:

_____

_____

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Developmental / Social

List your child's three greatest strengths:

1. _____

2. _____

3. _____

List your child's three greatest weaknesses or needed areas of improvement:

1. _____

2. _____

3. _____

List your child's main difficulties in school:

1. _____

2. _____

3. _____

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List your child's three main difficulties at home:

1. _____

2. _____

3. _____

Briefly describe the child's friendships: _____

_____

Briefly describe the child's hobbies or interests: _____

_____

What report card grades does the child usually receive? _____

Have these changed lately? ____Yes ____No If yes, how: _____

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Counseling Goals

What goals or changes would you like to see your child work towards in their counseling experience?

1.

2.

3.

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