Joyce Nebgen, MS, BCN, LMHC, LIMHP
Gil Nebgen, Ph.D, PE
Oldmarketneurotherapy.com
joyce@oldmarketneurotherapy.com 402-917-6418 (Gil)
1299 Farman St., Suite #335, Omaha, NE 68102

Child Intake Form

Name of Child: ___________________________ Age: ___ Birth Date: _________ Gender: ______

Parent/Guardian Name: _________________________________

Street Address: ____

City: _________________ State: ______________ Zip Code: ____________

Phone Numbers: Home: _____________ Work: ________________Cell: __________________

Child's School/Daycare: ____________________________ School Phone #: __________________

Grade: _________ Teacher: ___________________

Please list any medications your child is currently taking, including psychotropic medications:

____

____

Please describe any medical conditions of your child that I should be aware of (allergies, injuries, illnesses, etc):

____

____

Please describe your current household composition (names, ages, and relationship of those living with your child):

____

____

The reason I am seeking therapy for my child is:

____

____

What have you already tried to correct or resolve this problem?

____

____

____

What are you most concerned about?

____

____

____

What changes would you like to see as a result of therapy?

____

____

____

Child History

Name of Child: __________________________ Age: ___ Gender: ______

Were there any problems or complications during pregnancy or birth?----- yes no

Explain:____

Were there any developmental delays?-- yes no

Explain:____

Were there any early childhood problems with eye contact, being touched,

lines up toys, or upset with change in routine?---------------------------------- yes no

Explain:____

Has your child experienced any form of abuse (physical, emotional, sexual)? yes no

Explain:____

Has your child experienced any significant trauma or losses?------------------- yes no

Explain:____

Has your child experienced any divorces or separations?----------------------- yes no

Explain:____

Does your child have fears, is oversensitive, demanding, temper tantrums,

aggressive behavior, is hyperactive or has difficulty paying attention? ----- yes no

Explain:____

Does your child have difficulty at school or daycare?--------------------------- yes no

Explain:____

Does your child generally get along with other children his/her own age?- yes no

Explain:____

Does your child generally get along with adults?------------------------------- yes no

Explain:____

Does your child have unusual eating patterns?------------------------------------ yes no

Explain:____

Does your child have unusual sleeping patterns?--------------------------------- yes no

Explain:____

Has your child ever experienced a bump, jolt, hit his head or been knocked out? Played contact sports? Involved in a car accident?------------------------ yes no

Explain:____

Has your child received any previous counseling or treatment? Write name of counselor, reason for counseling and dates------------------------------------- yes no

Explain:____

____

Was counseling successful?-- yes no

Explain:____

List any medication providers. Was medication successful?--------------------- yes no

Explain:____

Does any family members, including extended family, suffer from any form of mental illness or substance abuse?-- yes no

Explain:____

List any legal history including adoption, foster care, guardianships, custody or visitation arrangements.

Explain:____

How would you describe your child's strengths and challenges?

Explain:____

____

List your child's support system (parents, grandparents, friends, family)?

Explain:____

____

Please list your expectations for your child's treatment outcomes?

Explain:____

____

Please share any other information that would help us to provide the best services to you and your family____

____

____