



Cornerstone Counselling Centre

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Intake Form – Parent of Child

CLIENT INFORMATION: Parent/Child

The following information will assist us when working with your child as it provides us with a more complete picture of his/her development to date. We have tried to be as complete as possible. If there are any questions that you do not wish to answer please leave them blank. We thank you for your assistance.

1. Parent/Guardian's name _____

2. Child's full name _____

3. Address _____ Postal Code _____

4. Birth Date _____ Age _____ Grade in School _____

5. Address if different from child's place of residence _____

6. Status of Child (*Circle one*): Biological Step Adopted Other

7. Marital Status (*Circle one*):

Married Common Law Separated Divorced Widowed Single

8. In instances where parents are separated or divorced, we require a copy of the custody agreement. If custody is shared, we also require written consent for counselling from both parents.

➤ Do you have sole legal custody of your child? Yes No

9. Siblings. List oldest to youngest. Use back of sheet if necessary.

(Circle) (Circle)

Name_____Age_____Gender M/F Home/Away Biological/Step

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Name_____Age_____Gender M/F Home/Away Biological/Step

10. Do any of your other children have any special concerns or issues?

Immediate Concerns

1. Who suggested you come to Cornerstone Counselling Centre?

2. Reason(s) for seeking counselling? _____

3. When did the problem(s) begin as far as you know? _____

4. Who is aware of the problem(s)? _____

5. Are there any significant changes in the home and/or in the child's life that have happened in the last year or two?

6. What would you like to see happen as a result of coming for help?

7. Has your child had any previous counselling? Yes No When?

Birth and Developmental History

1. Mother's health (if known) Medical complications Yes No

During pregnancy Alcohol/Drug abuse Yes No

Labour Complications Yes No

Medications taken Yes No

Medications taken: _____

Child Illness/Concerns

1. Problems with:

Stomach aches Yes No

Sight Yes No

Allergies Yes No

Hearing Yes No

Asthma Yes No

Speech Yes No

High Fever Yes No

Eating Yes No

Convulsions Yes No

Sleeping Yes No

Headaches Yes No

Wetting bed Yes No

➤ Other _____

2. Any hospitalization? Yes No Length of stay and reasons _____

3. Is your child on medication? Yes No

➤ List of medications:

➤ When did your child begin taking this medication? _____

Educational History

1. Has your child ever repeated a grade? Yes No

➤ Which one? _____

2. How many schools has your child attended to date? _____

3. Has your child ever required an aid or tutor? _____

4. Has your child ever had a psycho-educational assessment? Yes No

5. List three areas of strength of your child:

i) _____

ii) _____

iii) _____

Socialization

1. Does your child find it easy / difficult to make friends? (*Circle one*)

2. Has your child ever been bullied? Yes No

3. Has your child ever been a bully? Yes No

Comments _____
