

Intake Assessment

SS SuperStar Social Skills Group

Summer 2011

You may send these materials to: Central College Christian Counseling, 975 S. Sunbury Rd., Westerville, OH 43081 or fax them to: 614-865-0513, attention: Leslie Marshall. Please answer all items as fully, honestly and clearly as possible. Please print. If you need additional space, please use additional paper.

I would like to have my child, who is ____ yrs. old, attend the July 11 -1 4 camp.

Child's Name: _____ Birthdate: _____

Your Name: _____ Relationship to the child: parent legal guardian

Address: _____ City: _____ Zip: _____

Day phone number: _____ e-mail: _____

Child's primary care physician: _____

Address: _____ City: _____ Zip: _____

Phone number: _____ Fax number: _____

Name of person to contact in case of emergency: _____

Phone number: _____ Relationship: _____

How did you hear about the SS Superstar Social Skills Camp? Friend/Family
 Church (which one?) _____ School (which school?) _____
 Newspaper (which one?) _____ Doctor (whom?) _____
 Other _____

CHILD'S EDUCATION

Name of current school: _____ Most recent grade completed: _____

Address of school: _____ City: _____ Zip: _____

School phone number: _____ Best subject(s) _____

Worst subject _____ Number of years your child has attended this school: _____

Has your child been suspended this past school year? Yes No

If so, days of suspension: _____ Reasons: _____

Intake Assessment

SS SuperStar Social Skills Group

Summer 2011

Most recent prior school: _____

Address of school: _____ City: _____ Zip: _____

School phone number: _____ In what grades did he/she attend this school: _____

Reason(s) for leaving last school: _____

Days of suspension at previous school: _____ Reasons: _____

ABOUT YOUR CHILD

What social skills do you feel your child is lacking? _____

What problems do you experience that seem to stem from his/her lack of social skills? _____

What form of help have you sought to improve your child's social skills? (Circle all that apply)

Counselor Medicine Family Physician

Play Therapy Psychiatrist/Psychologist Smalls Group Work

Social Worker Church Other _____

If your child been in therapy/social skills groups before, please complete following:

Name/address of therapist/group	Starting date, duration and freq.	Reason for seeking therapy	Was it helpful?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

If involve in a small group in the past, how did your child perceive group experiences? _____

Intake Assessment

SS SuperStar Social Skills Group

Summer 2011

Define your goals for your child's involvement in this group. How would you know if this social skills group was successful for your child?

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Describe any current stressors (recent divorce, change of residence, death of loved one).

FAMILY HISTORY

Has any blood relative ever had any psychiatric disturbance, including depression, mania, schizophrenia, suicide, nervous breakdown, mental retardation, drug abuse, alcoholism, trouble with law enforcement, hallucinations, psychosis or any other emotional difficulty?

Yes No If yes, complete following:

Family Member's name and relationship to child	Symptoms (what you seen)	Diagnosis (if determined)

Has your child ever experienced any kind of sexual, physical or psychological abuse?

Yes No If yes, please explain: _____

Has your child ever witnessed any kind of sexual or physical abuse? Yes No If yes, please explain: _____

Intake Assessment
SS SuperStar Social Skills Group
Summer 2011
YOUR CHILD'S MEDICAL BACKGROUND

Does your child currently have a diagnosis that plays a part in their social skills (Asperger's Syndrome, ADHD, etc.)? Yes No If yes, please provide diagnosis: _____

Date of diagnosis: _____ Name of diagnosing physician: _____

Address: _____ City: _____ Zip: _____

Phone number: _____ Fax number: _____

Describe any current illnesses and any symptoms (fever, pain or unexplained weight loss).

Medication	Dose	Purpose	How long on meds.?	Is it useful?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Attach sheet if you need additional space.

INSURANCE

Would you like us to contact your insurance company to inquire about coverage? Yes No
 If yes, complete the following:

Name of Insured: _____ Birthdate: _____

Insured's Employer: _____

Insurance Co. _____ Membership # _____

Group #: _____ Behavioral Health Phone: _____

Customer Service Phone: _____ Address: _____

Address: _____ City: _____ Zip: _____

Thank you for your honesty.