SPROUT PLAY THERAPY
& COUNSELING SERVICES

Initial Intake Assessment 2025

Child's Name: _____ Age: _____ Date: _____

Person Filling Out: _____ Relationship to Child: _____

	Yes	Sometimes	No
Does your child have difficulty falling asleep?	◯	◯	◯
Does your child have difficulty maintaining friendships?	◯	◯	◯
Is your child willing to try new things?	◯	◯	◯
Does your child display enjoyment doing activities?	◯	◯	◯
Does your child have difficulty maintaining concentration?	◯	◯	◯
Does your child have difficulty paying attention to one task for long periods of time?	◯	◯	◯
Does your child have difficulty completing tasks that they start?	◯	◯	◯
Does your child argue frequently?	◯	◯	◯
Does your child have difficulty getting their mind off of certain thoughts or ideas?	◯	◯	◯
Does your child often express confusion with tasks?	◯	◯	◯
Does your child have a history of bullying other children or peers?	◯	◯	◯
Has your child ever engaged in self-harm?	◯	◯	◯
Has your child ever distroyed things that belong to his/her family members?	◯	◯	◯
Does your child frequently lie?	◯	◯	◯
Does your child struggle to eat well?	◯	◯	◯
Does your child seem to not be liked by other children?	◯	◯	◯
Does your child have a history of constipation or other toileting concerns?	◯	◯	◯
Does your child express feeling aches and pains that are not associated with an injury or illness?	◯	◯	◯

	Yes	Sometimes	No
Does your child struggle to get a long with other children?	◯	◯	◯
Is your child easily jealous?	◯	◯	◯
Does your child fear certain animals?	◯	◯	◯
Does your child fear certain places or situations?	◯	◯	◯
Does your child fear that they may do something wrong?	◯	◯	◯
Does your child express the need to be perfect?	◯	◯	◯
Does your child state "no one loves me"?	◯	◯	◯
Does your child express feeling worthless?	◯	◯	◯
Does your child get teased a lot?	◯	◯	◯
Does your child get into fights?	◯	◯	◯
Does your child express express hearing voices that are not physically present?	◯	◯	◯
Does your child seem impulsive?	◯	◯	◯
Does your child prefer to be along versus with others?	◯	◯	◯
Does your child appear nervous or tense?	◯	◯	◯
Does your child have a history of nightmares?	◯	◯	◯
Does your child experience frequent stomach aches?	◯	◯	◯
Does your child exprress having frequent headaches?	◯	◯	◯
Does your child seem to be hyperactive?	◯	◯	◯
Is your child often restless?	◯	◯	◯
Does your child have difficulty paying attention to one task for long periods of time?	◯	◯	◯

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Initial Intake Assessment 2025 - Continued

Adverse Childhood Experiences (ACEs) Assessment

Has your child ever had experience with any of the following? Please check box if applicable.

- Did a parent or other adult in the household often or very often, swear at you, insult you, put you down and/or threaten you in a way that made you think that you might be physically hurt? ◯
- Did a parent or other adult in the household often or very often, push, grab, slap, or throw something at you? ◯
- Did an adult or person at least 5 years older ever touch or fondle or have you touch their body in a sexual way? Did anyone attempt or actually have oral, anal, or vaginal intercourse with you? ◯
- Did you often or very often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it? ◯
- Did a household member ever go to prison, or was constantly in and out of jail? ◯
- Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school? ◯
- Has your child experienced discrimination? ◯
- Has your child ever had problems with housing? ◯
- As a child, did you ever live with anyone who was a problem drinker or alcoholic or lived with anyone who used street drugs? ◯
- Was a household member ever depressed; mentally ill or sent to a mental hospital? Has a family member ever attempted suicide? ◯
- As a child, were your parents ever separated (didn't live together) or divorced? ◯
- Was your mother or stepmother often, or very often pushed, grabbed, slapped; or had something thrown at her? Sometimes, often, or very often kicked, bitten, hit with a fist or something hard? Ever threatened or hurt by a knife or gun or other weapon? ◯
- Did you often or very often feel that no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other? ◯
- Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more? ◯
- Has your child ever been separated from their parent or caregiver due to foster care, or immigration? ◯

Please provide further descriptions to anything that was marked above:

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Initial Intake Assessment 2025-Continued

Please provide any further explanations to anything that was marked on the first page:

If things were improved, what would be different?

Please share about your child's strengths.

Please share about your child's interests, hobbies, and things that bring them joy.

Please provide any other helpful information or concerns:

Thank you!