Adolescent & Child Intake Information

Please provide the following information and answer the questions below. Please complete this form and bring it to your child's first session. Please note: Information you provide here is protected as confidential information.

GENERAL INFORMATION

1. Child's name: ____
(Last) (First) (Middle Initial)

Client's Date of Birth: __________________ Age: ______ Gender: (circle) Male Female

Child's Address: ____

City: ____ State: _________ Zip: _____________

2. Parent's Names: (include step-parents, foster parents, etc.)

____
(Last Name) (First Name) (Middle initial)

Cell Phone: ____________________Cell Carrier Name: ___________ May we leave a message? ____Yes ____No

E-mail Address: ____ May we email you? ____Yes ____No

____
(Last Name) (First Name) (Middle initial)

Cell Phone: ____________________ Cell Carrier Name: __________ May we leave a message? ____Yes ____No

E-mail Address: ____ May we email you? ____Yes ____No

(Please note: E-mail correspondence is not considered to be a confidential medium of communication)

3. Natural Child: (circle) Yes No If adopted, at what age: _____ Foster since: / /

Comments about custody & visitation (if applicable)

____

____

4. Primary reason you are concerned about your child?

____

____

____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom or problem that is a concern. How long has it been a problem?

_____	Sleep problems	_____	Morbid thoughts
_____	Lack of interest in activities	_____	Suicidal thoughts or threats
_____	Unassertive	_____	Suicidal plans / attempts
_____	Fatigue / Low energy	_____	Mood swings
_____	Concentration problems	_____	Depression
_____	Appetite / weight changes	_____	Changed level of activity
_____	Withdrawal	_____	Cries easily
_____	Forgetful / memory problems	_____	Talks excessively / interrupts
_____	Short attention span	_____	Easily distracted
_____	Aggressive behavior	_____	Irritable
_____	Can’t sit still	_____	Impulsive
_____	Not interested in peers	_____	Difficulty following rules
_____	Picked on / bullied by peers	_____	Problem completing schoolwork
_____	Excessive worry / fearfulness	_____	Nightmares
_____	Anxiety or panic attacks	_____	Frequent tantrums
_____	Social fears, shyness	_____	Resistive to change
_____	Separation problems	_____	School refusal
_____	Bedwetting / soiling	_____	Perfectionism
_____	Headaches, stomachaches	_____	Odd hand / motor movement
_____	Odd beliefs / fantasizing	_____	Hallucinations
_____	Lying	_____	Stealing
_____	Trouble with the law	_____	Being destructive
_____	Running away	_____	Fire setting
_____	Truancy / skipping school	_____	Hurting others / fighting
_____	Hurting others sexually	_____	Acts as if has no fear
_____	Alcohol / drug use	_____	Short tempered
_____	Argumentative / defiant	_____	Easily annoyed/annoys others
_____	Swears	_____	Discipline problem
_____	Blames others for mistakes	_____	Angry and resentful

Comments Related to Symptoms or Problems

____

BROTHERS and SISTERS

First/Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

Please list any other family members living in the same household: ____

Please list other unrelated people living in the same household: ____

Emergency Contact Name: __________________________________ Relationship to Contact: _______________

Home Phone: (   ) _______ - _____________Cell Phone: (   ) _______ - _____________

SCHOOL HISTORY

1. Present School: ______________________________________ Grade: _________

2. Has your child ever repeated any grade? __________________________________

3. Is your child receiving special education services? No ______   Yes ______, what kind?

____

4. Please describe academic or other problems your child has or has had in school?

____

DEVELOPMENTAL HISTORY

- Mother used during pregnancy: alcohol ______ drugs ______ cigarettes _____ none ____
- Delivery: Normal ______ Breech ______ Cesarean ______ Birth weight ______ lbs. ______ ounces

  Full-term ______ Premature ______. If premature, number of weeks ______
- Problems at birth: (for example: infant given oxygen, blood transfusion, place in an incubator, etc.)
- State approximate age when child did the following:

  Walked alone _____ Said first word _____ Used 2-word phrases _____
- Understood and followed simple directions _____
- Reasonably well toilet trained _____

- Did child cry excessively? _____ Rarely cried _____
- In the first two years, did your child experience: ____Separation from mother, ____Out of home care, ____Disruption in bonding, ____Depression of mother, ____Abuse, ____Neglect, ____Chronic pain, ____Chronic Illness, ____Parental Stress
- Any head injuries or loss of consciousness? Yes _____ No _____

MEDICAL HISTORY

- Current Medical Conditions:

  ____

  ____

- Does your child have a Primary Care Physician? No _____ Yes _____
- History of medical treatments, serious illness, injury, handicaps, or hospitalization?

  No _____ Yes _____ (provide information for each occurrence)

  Date: / / Describe: ____

  Doctor's Name: ______________________________ Hospital: ___________________________

  Current Status or Outcomes? ____

  Date: / / Describe: ____

  Doctor's Name: ______________________________ Hospital: ___________________________

  Current Status or Outcomes? ____

- Is your child currently being seen by another mental healthcare provider? No ______ Yes _____
- Has your child previously received any type of mental health services (psychotherapy, psychiatric, etc.)?

  _____No _____Yes (provide information for each occurrence)

  Date: / / Describe: ____

  Counselor or Doctor's Name: ____

  Current Status or Outcomes? ____

- Is your child currently taking any medications? No ____ Yes ____

  If yes, please list:

  Medication Name: ______________________________ How Long? __________

  Medication Name: ______________________________ How Long? __________

Have you/your child ever been prescribed psychiatric medication? ____Yes ____No

If yes, please list and provide dates:

Medication Name: ________________________________ Dates: ___________ to __________

Medication Name: ________________________________ Dates: ___________ to __________

- List any medicines previously used for emotional problems: were they helpful?

  ____

- Allergies to drugs or medicines? No ____ Yes ____ (list) __________________________________
- Allergies to any foods? No ____ Yes ____(list) ____
- Describe allergic reactions to drugs, medicines or foods: __________________________________
- Are there any foods that you limit or do not give this child? No ____ Yes ____(list)

  ____

- Allergies to environmental conditions? No ____ Yes ____(list)

  ____

- Does anyone in the household smoke? No ____ Yes ____
- About how many hours does this child watch TV, videos, play video games, etc. per day _______
- Are you afraid someone you know may injure/harm this child? No ____ Yes ____
- Does this child have a Health Care Directive? No ____ Yes ____ If yes, please list where (clinic) it is on file

  ____

- Any previous testing (school/psychological)? No _____ Yes _____ Whom/where

  ____when______________

- Do you think your child's use of chemicals is a problem? No _____ Yes _____

  Type: Alcohol _____ Marijuana _____ Other drugs ____________________

  Comments: ____

- Has your child had any history of self-harm or suicidal attempts? No _____ Yes____

  Describe if applicable: ____

  ____

FAMILY MENTAL HEALTH HISTORY

In this section, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ex. Father, grandmother, uncle, etc.)

			Family Member
Alcohol/Substance Abuse	____No	____Yes	______________________________
Anxiety	____No	____Yes	______________________________
Depression	____No	____Yes	______________________________
Domestic Violence	____No	____Yes	______________________________
Eating Disorders	____No	____Yes	______________________________
Obesity	____No	____Yes	______________________________
Obsessive Compulsive Behavior	____No	____Yes	______________________________
Schizophrenia	____No	____Yes	______________________________
Suicide Attempts	____No	____Yes	______________________________
Self-Harm	____No	____Yes	______________________________

Comments related to Family Mental Health History:

____

____

LIFE STRESSORS/TRAUMA HISTORY

- Has your child ever been a victim of physical abuse? ____No ____Yes ____Suspected

  Specify: ____

- Has your child ever been a victim of sexual abuse? ____No ____Yes. ____Suspected

  Specify: ____

- Has your child ever experienced significant trauma? ____No ____Yes. ____Suspected

  Specify: ____

- Other stressors or traumas? ____

ADDITIONAL INFORMATION

1. Is your child currently employed? ____No ___Yes

   If yes, what is your/your child current employment situation?

2. Do you consider your child to be spiritual or religious? ____No ____Yes

   If yes, describe your/your child's faith or belief: ____________________________________

3. What do you consider to be some of your child's strengths?

4. What do you consider to be some of your child's weaknesses?

5. What would you like to accomplish during your child's time in therapy?

6. Any additional comments or information that would be helpful to us?

Signature of person completing this form / relationship to child:

____ ____________________ Date: / /

Name Relationship