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Child & Adolescent Intake Information

Please fill out this form and bring it to your child's first session.

Child's Name: ____ Date:____________

Birth date: ______/______/______ Age: _________ Gender: ______________________

Address: ____

City, State: ____ Zip: ___________

Parent/ Guardian Name(s):____

Home Phone: (____) __________________ Is it ok to leave a message? □Yes □No

Cell/Other Phone: (____) ________________ Is it ok to leave a message? □Yes □No

E-mail: ______________________________________ May I email you? □Yes □No

Referred by (if any):____

What is the main reason for seeking counseling? __________________________________

____

____

Does your child have a learning or physical disability? __Y, __N, __Maybe. Specify: ______________

____

Does your child have a mental health diagnosis? __Y, __N, Specify: ______________________

____

School:___________________________________ Teacher:_____________ Grade: _________

How does your child do in school academically? _________________________________

How does your child do in school behaviorally?__________________________________

Medical History

List any pregnancy issues or birth complications (Ex: Premature, jaundice, C-section, mother's use of alcohol/drugs, extreme stress, etc.)____

Reached developmental milestones: __On time, __Early, __Late __ (Specify if late) ________________

____

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, significant illness, etc.)
____

____

Does child use: __ Cigarettes, __ Alcohol, __ Drugs

Specify amount and frequency: ____

Primary Care Physician: ___________________________ Phone:____________ Last seen on: _______

Psychiatrist: ____________________________________ Phone:____________ Last seen on: _______

Current medications: (Include dosage and frequency): ____

____

Does your child have any difficulties with sleep? (too little, too much, difficulty falling asleep or staying asleep, night terrors, sleep walking, etc.) ____

____

Other physical or emotional health issues?: ____

Do you have any nutritional concerns? (Overall diet, picky eater, weight issues, food allergies or sensitivities) ____

____

How would you describe your child? ____

____

____

Your family relationship/home environment? ____

____

____

Family History

Biological Dad:_______________________________________ DOB:______________________

Biological Mom:______________________________________ DOB:______________________

___/___/___ Married; ___/___/___ Separated; ___/___/___ Divorced

Siblings:

Name: ______________________________ Age:____ Name: ____________________________ Age: ____

Name: ______________________________ Age:____ Name: ____________________________ Age: ____

Name: ______________________________ Age:____ Name: ____________________________ Age: ____

Other people in household, if different from above: ____

____

Does father work outside of the home? __Y, __N; Occupation: __________________________________

Hours:__________ Father's highest level of education: ____

Does mother work outside of the home? __Y, __N; Occupation: __________________________________

Hours:__________ Mother's highest level of education: _______________________________________

If separated or divorced, visitation schedule: ____

Does either parent have legal issues? ____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, AD/HD, schizophrenia, etc.): __________________

____

____

Have children witnessed domestic violence? __Y, __N, Specify: _________________________________

____

How is your child disciplined? Please list each method and frequency of use: _______________________

____

____

Trauma History

Has your child been verbally abused? __Y, __N, __Suspected. Specify: ___________________________

____

Has your child been physically abused? __Y, __N, __Suspected. Specify: ________________________

____

Has your child been sexually abused? __Y, __N, __Suspected. Specify: _________________________

____

Other stressors or traumas? ____

____

Circle the symptoms your child/adolescent displays and list the number of times per week it is displayed:

Anger	Anxiety	Bed wetting
School refusal	Conduct problems	Difficulty with concentration
Depression	Easily distracted	Bullying behavior
Drug or alcohol use	Hyperactivity	Suicidal thoughts
Hyper vigilance	Difficulty with school work	Isolation
Lack of empathy	Lack of motivation	Lethargy
Low impulse control	Defiance	Low self-esteem
Lying	Nightmares	Cuts self
Obsesses	Over/Under eating	Phobias
Peer problems	Running away	Victim of bullying
Shyness	Sleeplessness	Stealing
Tantrums	Somatic Symptoms: Headaches/Stomachaches, etc.	

Other: ____

How does your child/adolescent handle anger? ____

____

Has your child/adolescent experienced any significant loss? If yes, explain: _______________________

____

What do you view as your child's/adolescent 's major strengths and positive traits? _________________

____

____

What do you see as your child's areas of struggle or difficulty? ________________________________

____

What are your child/adolescent's hobbies? ____

____

What are your child/adolescent's responsibilities at home? ____________________________________

____

How well does your child/adolescent's handle these responsibilities? ______________________________

____

Briefly describe your goals for your child/adolescent's therapy: ____________________________________

____

____

What are your child's goals for therapy: ____

____

Has your child/adolescent requested therapy (or willingly agreed to therapy)? What is their understanding for the reason to attend therapy? ____

____

Please list any other information you deem to be important for the therapist to know: ________________

____

____

____

____ ____________________________________
Parent Signature Date

____ ____________________________________
Parent Signature Date