CHILD AND ADOLESCENT INTAKE FORM

Personal Information:

Name: _____ Date: _____

Gender: _____ Ethnic Origin: _____ Date of Birth:_____

Address: _____ City: _____ Zip: _____

Emergency contact 1: _____ Ph #: _____ Relationship: _____

Emergency contact 2: _____ Ph #: _____ Relationship: _____

School/Daycare:_____ Grade: _____

Insurance: _____ (We collect information on insurance in case an outside referral is necessary).

People living in same household as child:

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Presenting Problems:

Check any areas in which you have concerns for your child:

- ☐ Physical health
- ☐ Weight
- ☐ Diet and eating
- ☐ Hygiene
- ☐ Sleeping
- ☐ Motor skills
- ☐ Language skills
- ☐ Memory issues
- ☐ Sensory issues
- ☐ Potty training
- ☐ Bed wetting
- ☐ Separation anxiety
- ☐ Nightmares
- ☐ Nervous habits
- ☐ Anxiety / Fear
- ☐ Grief
- ☐ Depression
- ☐ Self – harm
- ☐ Suicidal thoughts
- ☐ Alcohol / Drug use
- ☐ Sexual acting out
- ☐ Anger
- ☐ Aggressive behaviors
- ☐ Hurting animals
- ☐ Fire setting
- ☐ Delinquent behaviors
- ☐ Legal situation
- ☐ Concentration / Attention
- ☐ School
- ☐ Bullying
- ☐ Other _____

Explain the item(s) you checked (continued on next page):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What made you decide to take your child to counseling? What are your goals for counseling?

_____
_____
_____

What are some of your child's strengths?

_____
_____
_____

What discipline is used in the home?

_____
_____
_____

Please describe how your child gets along with his or her family.

_____
_____
_____

Please describe your child's relationship with his or her friends/peers.

_____
_____
_____

Has your child experienced any significant changes in the last year? (changed schools, new people in the home, loss of pet).

_____

_____

_____

Medical History:

Has your child previously or currently been under the care of a psychiatrist? Yes ☐ No ☐

Name of Psychiatrist: _____

Agency/Practice: _____Dates seen: _____

Has your child received mental health treatment in the past? Yes ☐ No ☐

If yes, for what, when and where? _____

_____

_____

Is your child currently on medication? Yes ☐ No ☐

Name of Medication	Reason for Medication	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Primary Care Physician or Pediatrician: _____

When was your child's last physical exam: _____

Does your child have any known medical conditions or allergies? Yes ☐ No ☐

If yes, please indicate these conditions: _____

_____

_____

Developmental History:

Did your child or their birth mother experience any complications with birth, delivery or immediately after birth? Yes ☐ No ☐

If yes, specify: _____

_____

_____

Did the birth mother experience any physical or emotional abuse, consume alcoholic beverages or abuse any street drugs during pregnancy? Yes ☐ No ☐

If yes, specify: _____

_____

_____

Is there any family history of mental health concerns or substance abuse? Yes ☐ No ☐

If yes, specify: _____

_____

_____

Has your child experienced any history of physical, sexual or emotional abuse? Yes ☐ No ☐
If yes, specify: _____
_____
_____

Has your child experienced a history of prolonged separations, including adoption or foster care?
Yes ☐ No ☐
If yes, specify: _____
_____
_____

Has you child been exposed to any other traumatic events? (an accident or injury, loss of a loved one, witnessing domestic violence). Yes ☐ No ☐
If yes, specify:_____
_____
_____

Did your child experience any developmental delays? (i.e. talking, crawling, walking, potty training, etc.)
Yes ☐ No ☐
If yes, specify: _____
_____
_____

Is your child currently receiving special services at school? Yes ☐ No ☐
If yes, specify: _____
_____
_____

Has your child ever failed a class or been held back for academic reasons? Are there any current academic concerns? Yes ☐ No ☐
If yes, specify: _____
_____
_____