Child / Adolescent Intake Form

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your counselor will discuss your responses with you in your interview.

To be completed by Parent/Guardian:

Child's Name____ First Visit Date: ___________________________

Form Completed by: ____ Relationship: ______________________________

Child's Legal Guardian: _____________________________________ With Whom does Child Live?_________________

(A copy of the final divorce decree is required if parents are divorced.)

Would you like to receive a discreet phone call to remind you of your appointment 24 hours in advance?

☐Yes ☐No If, yes, I prefer the following telephone number to be used: ______________________________

Email Address: ____ (May email: yes/no)
Can we email you our newsletter or information about any upcoming seminars? ☐Yes ☐No
How did you hear about us? ____

Child's Date of Birth: _____/______/________ Age: ____________ Gender: ☐Male ☐Female

School: __________________________________ Grade: _______ School Counselor: _________________________

Mother's Address: ____ (May receive mail: yes/no)

City: _________________________________ State: _____________ Zip: ____________

Home Phone: _______________________________________ (May call: yes/no; May leave message: yes/no)

Work Phone: _______________________________________ (May call yes/no; May leave message: yes/no)

Cell Phone: ____ (May call yes/no; May leave message: yes/no)
Mother's Marital Status: ☐Married ☐Never married ☐Separated ☐Divorced ☐Widowed

Number of Marriages & Length of Each: ____

Are you currently involved in a custody dispute? ☐No ☐Yes
Are you currently involved in a legal dispute? ☐No ☐Yes

Religious Affiliation as a Child: ____________________________ As an Adult: _________________________________

Occupation: ____ Education: ____________________________________

Father's Address: ____ (May receive mail: yes/no)

City: _________________________________ State: _____________ Zip: ____________

Home Phone: _______________________________________ (May call: yes/no; May leave message: yes/no)

Work Phone: _______________________________________ (May call yes/no; May leave message: yes/no)

Cell Phone: ____ (May call yes/no; May leave message: yes/no)
Father's Marital Status: ☐Married ☐Never married ☐Separated ☐Divorced ☐Widowed

Number of Marriages & Length of Each: ____

Are you currently involved in a custody dispute? ☐No ☐Yes
Are you currently involved in a legal dispute? ☐No ☐Yes

Religious Affiliation as a Child: ____________________________ As an Adult: _________________________________

Occupation: ____ Education: ____________________________________

Name of Person(s) to contact in case of Emergency:

1. ____ Phone: _________________________
2. ____ Phone: _________________________

Immediate Family Members (parents, siblings)

Relationship	Name	Age	Level of Education/ Grade	Occupation	Does child get along with them?
Mother					
Father					
Step-Parent					
Step-Parent					
Sister(s)					
Brother(s)					
Step-Sibling(s)					
Half-Sibling(s)					

Does anyone in your family suffer from alcoholism, and eating disorder, depression or anything that might be considered a mental disorder? Please explain: ____
____
____

MEDICAL INFORMATION

Primary Care Physician: Name ____ Phone _______________________
Address ____

Has your child ever seen a mental health professional (psychiatrist, psychologist or counselor)? Yes/No

Previous Mental Health Professional/Agency: ____

Phone: _____________________ Dates of Service: from ____/____ to ___/____

Has your child ever been hospitalized for mental health concerns? Yes/No

Please circle the following items for which a diagnosis has been given: Depression, ADHD-Hyperactive, ADHD-Inattentive, Conduct Disorder, Learning Disability, Anxiety/Nervousness, Panic Attack, Bipolar, Schizophrenia, Oppositional Defiant Disorder, Mood/Anger, Tics, Insomnia/Sleeplessness, Obsessive/Compulsive, Addictions, Post Traumatic Stress Disorder, Other:____

List medications child is currently taking:
Medication: ____ Dosage: ___________

Medication: ____ Dosage: ___________

Medication: ____ Dosage: ___________

Please provide a brief description of why you are seeking counseling/therapy services for your child:

___

___

Has anything happened that may have brought on/intensified your child's problems? Yes/No. If yes, please explain:

___

___

When did your child first begin to experience these problems? ____

How often does your child experience these problems? Check the one that best describes your child's current experience:

__ Most of the day, every day
__ Some part of the day, every day
__ Most of the day on most days
__ Some part of the day on most days
__ More than once a week
__ More than once a month
__ Other ________________________

How much is/are the problems affecting your child? _____Mildly _____ Moderately _____Severely

In what areas do your child's problems impact his/her life? (Check all that apply)
__ Lifestyle (the way your child lives his/her life)
__ Activities (things your child normally does or would like to do)
__ Relationships (your child's ability to form or maintain relationships with others)
__ Eating
__ Sleeping
__ Mood

My child's sources of satisfaction:

____

____

My child's sources of stress:

____

____

My child's leisure activities:

____

____

My child's typical day:

____

____

____

____

Briefly describe any significant event in your child's development (including physical, psychological, emotional, intellectual, social, spiritual, and academic):

____

____

____

____

CURRENT CONCERNS

Indicate severity of the following items (1-mild; 2-moderate; 3-severe). ***Circle*** *any items that you see as very significant.*

___ Adjustment to life changes (parents' divorce, move, loss/death of someone close, etc.)
___ Abuse (physical, emotional, or sexual)
___ Aggressiveness
___ Anger
___ Bed wetting
___ Behavior problems
___ Bowel disturbances
___ Compulsive behavior
___ Crying Spells
___ Difficulty having fun
___ Difficulty making friends
___ Disturbing memories (past abuse, neglect or other traumatic experience)
___ Divorce
___ Dizziness
___ Drug or alcohol use (both legal and illegal drugs)
___ Easily distracted
___ Eating problems (purging, bingeing, overeating, hoarding, severely restricting diet)
___ Excessive Behaviors (spending, gambling, etc.)
___ Excessive boredom
___ Fainting spells
___ Family or Step-family relationship
___ Fatigue
___ Fears or Phobias
___ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, etc.)
___ Feeling angry or irritable
___ Feeling ashamed
___ Feeling distant form God
___ Feeling fat
___ Feeling guilty or shameful
___ Feeling of inferiority
___ Feeling "numb" or cut off from emotions
___ Feeling "on top of the world"
___ Feeling sadness or depression or suicidal urges *related to grief*
___ Feeling sadness or depression or suicidal urges *NOT related to grief*
___ Health concerns (physical complaints and/or medical problems)
___ Hearing voices
___ Hyperactive
___ Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
___ Inability to control thoughts
___ Lack of motivation
___ Learning/Academic difficulties
___ Loneliness
___ Making/keeping friends
___ Nightmares
___ No appetite
___ Non-family relationship (friend, teacher, etc.)
___ Palpitations
___ Parent/ child relationship problems
___ Personal Growth (no specific problem)
___ Poor home environment
___ Problem with alcohol
___ Religious or Spiritual concerns
___ Self-Control problems
___ Self esteem problems
___ Self injurious behaviors
___ Sexual problems/behavior
___ Sexual identity concerns
___ Sleep problems (nightmares, sleeping too much or too little, etc.)
___ Significant other relationship
___ Social skills or support
___ Stress
___ Suspicious of other people
___ Takes sedatives
___ Thoughts of hurting self or others
___ Unable to relax
___ Unable to sit still
___ Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___ Unusual experiences (loss of periods of time, sensing unreal things, etc.)

IMPACT OF PROBLEM ON FAMILY

Read each of the items below. Write in the number that corresponds with the level of impact your child's problem has in each area.

0 No impact
1 Slight impact
2 More than slight impact, but less than moderate
3 Moderate
4 More than moderate
5 Serious impact

	1. Time mother spends with the other children in the family		11. Visiting friends in their homes
	2. Time father spends with the other children in the family		12. Emotional well being of mother
	3. Amount of time mother spends with father		13. Emotional well being of father
	4. Amount of time father spends with mother		14. Emotional well-being of brother(s) and sister(s)
	5. Family time spent with relatives		15. Family finances
	6. Going out to eat as a family		16. Relationship between parents
	7. Going out as a family other than to eat		17. Relationships among the children of the family
	8. Going on a family vacation		18. Relationship between child and parents
	9. Having friends visit our home		19. Relationship between parents and the other children of the family
	10. Mealtimes		20. Spending leisure time together