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CHILD/ADOLESCENT INTAKE FORM

Child's Legal Name: _____ Nickname: _____

Child's Address: _____ City_____State _____ Zip_____

Child's D.O.B ____/_____/_____ Age: _____ Gender: _____

Who referred you: _____

Coordination of Care:

It is important for your child's health care providers to speak to each other so we may work together. Please complete the information below and indicate your approval for us to coordinate your child's care.

Primary Care Physician:_____Phone:_____

Address:_____City_____State_____Zip_____

May we contact your physician: □YES □ NO □ I DO NOT HAVE A PHYSICIAN

Psychiatrist/therapist:_____Phone:_____

Address:_____City_____State_____Zip_____

May we contact your Psychiatrist/therapist: □YES □NO □ I DO NOT HAVE A Psychiatrist/therapist

FAMILY INFORMATION

Parent 1: _____ □ Biological □ Adoptive □ Step

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone: _____ □Work □ Home

Is parent employed outside the home? □Y□ N Does parent live with child/adolescent? □ Y □N

Place of Employment: _____ Occupation: _____

Parent 2: _____ □ Biological □ Adoptive □ Step

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone: _____ □Work □ Home

Is parent employed outside the home? □Y□ N Does parent live with child/adolescent? □ Y □N

Place of Employment: _____ Occupation: _____

STATUS OF PARENTS: □ Married __/__/__ □ Separated__/__/__ □ Divorced__/__/__ □ Unmarried
□ Other (Specify): _____

If separated or divorced, visitation schedule: _____

If other caregiver, please list below:
Caregiver's Name: _____ Relation to Child: _____
Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone: _____ □Work □ Home

Is caregiver employed outside the home? □Y□ N Does caregiver live with child/adolescent? □ Y □N

Place of Employment: _____ Occupation: _____

Siblings (Oldest to Youngest):

_____ Age: _____
_____ Age: _____
_____ Age: _____

Others living in the home:

_____ Relation _____
_____ Relation _____
_____ Relation _____

What are five adjectives that describe:

Mother: _____
Father: _____
Child: _____
Parental Relationship: _____

Does either parent have legal issues?: _____

Has child witnessed parental arguments? ___ Yes ___No Specify: _____

Has child witnessed domestic violence? ___Yes ___No Specify: _____

DISCIPLINE PHILOSPOHY

Who usually disciplines your child? _____

Do the adults caring for the child agree on discipline? _____

How is your child disciplined?:

□ Spank □ Take away privileges □ Yell □ Send to room □ Talk to/Reason with □ Time out □ Extra Chores

□ OTHER: _____

Do you reward your child for obeying or behaving well?	□ Often	□ Sometimes	□ Never
Do you ignore your child when he/she is misbehaving?	□ Often	□ Sometimes	□ Never
Do you ask your child what his/her plans are for the day?	□ Often	□ Sometimes	□ Never
Does your child talk you out of being punished?	□ Often	□ Sometimes	□ Never
Do you let your child out of punishments?	□ Often	□ Sometimes	□ Never

(e.g., lifting restrictions earlier than you originally said)

MENTAL HEALTH HISTORY

Previous Mental/Behavioral Health Providers:

Name: _____ Dates: _____Issues or Diagnosis: _____

Name: _____ Dates: _____Issues or Diagnosis: _____

Current mental health medication (include dosage and frequency): _____

_____

Past mental health medications tried and reasons stopped: _____

_____

List past suicide attempts or hospitalizations: _____

List any history or suspicion of mental illness or addiction in immediate or extended family
(e.g. depression, anxiety, suicide attempts/completions, ADHD, alcoholism, drug abuse, etc.):

_____

ACADEMIC PERFORMANCE

Child's School: _____ Teacher/Counselor: _____ Grade: _____

Has child repeated any grades? □ N □ Y, what grade(s) and why? _____

Has child been received or participated in any of the following services:

□ Learning disabilities
□ Resource room
□ Emotional/behavioral disorders
□ Speech/language therapy
□ Occupational therapy
□ Autism services
□ Tutoring
□ Individualized Education Plan (IEP)
□ 504 plan
□ Gifted/High ability programs
□ Social skills group
□ Other: _____

How does your child do academically in school? _____

Any suspensions, expulsions, or other behavioral issues: _____

Child's strengths in school/subjects: _____

Child's weaknesses in school/subjects: _____

DEVELOPMENTAL HISTORY

Any health problems in mother during pregnancy or post-partum including depression or anxiety:

_____

Delivery was: □ Vaginal □ Caesarean List any complication during labor and delivery:

_____

Baby was: □ Full-term □ Premature, by how many weeks? _____

What substances (drugs, alcohol, medications, caffeine) did mother use during pregnancy (indicate frequency)?

_____

Please check if there were any problems during infancy or toddler years with:

□ Feeding problems
□ Colic
□ Delayed responses
□ Hearing
□ Difficult to soothe
□ Didn't like to be held
□ Poor eye contact
□ Overly shy
□ Very outgoing
□ Overly compliant
□ Very insistent
□ Overactive
□ Not Active
□ Liked to play alone
□ Repetitive play
□ Loud

Please check if there were any delays with:

□ Rolling over
□ Sitting up unassisted
□ Crawling
□ Walking
□ Fine motor skills
□ Gross motor skills
□ Toilet Training
□ Speech/ Language

In the first two years of life, did your child experience:

□Abuse □ Neglect □ Parental Stress □ Chronic Pain □ Separation from Mother □ Out of Home Care

□ Disruption in Bonding □Depression of Mother

MEDICAL HISTORY

How would you describe your child's health? □ Very Good □ Good □ Fair □ Poor □ Very Poor

Specify any problems with hearing, vision, coordination, or speech _____

Are immunizations up to date? □ Yes □ No Last doctor's visit? _____/ _____ Dentist? _____/ _____

Any Allergies? _____

Which of the following has the child had? (Check all that apply)

□ Stomachaches
□ High fevers
□ Asthma
□ Constipation
□ Chronic diarrhea
□ Urinary tract infection
□ Chronic pain
□ Lead poisoning
□ RSV
□ Chicken pox
□ Chronic ear infections
□ Croup
□ Pneumonia
□ Seizures
□ Headaches
□ Loss of consciousness
□ Sleep difficulties
□ Nightmares
□ Clumsiness
□ Nail biting
□ Failure to thrive
□ Thyroid disorder
□ Diabetes
□ Tics/twitching
□ Kidney disease
□ Blood disorder
□ Lead poisoning
□ Toxic ingestion
□ GI disease
□ Lung disease
□ Heart disease
□ Liver disease
□Broken bones
□ Loss of consciousness
□ Severe lacerations
□ Head injury
□ Severe bruises
□ Eye injury
□ Sutures
□ Loss of teeth
□ Other (specify): _____

Has your child had any other medical problems, illness, injuries, surgeries, or hospitalizations?

□ Yes □ No If yes, specify: _____

Does your child have bladder or bowel control problems? □ Yes □ No If yes, explain

_____

Typical Bedtime: _____ Typical Wake time: _____Wk Days _____Wk Ends

Describe child's sleep patterns and habits:

□ Sleeps all night without disturbance
□ Difficulty falling asleep
□ TV in bedroom
□ Awakens during the night/restless
□ Early morning awakening
□ Watches TV/plays video games up to bedtime
□ Severe snoring
□ Sleeps outside of bedroom
□ Gets up after bedtime to watch TV/play games
□ Sleepwalking

Describe this child's appetite:

□ Overeats □ Average □ Under eats □ Binges □ Purges □ Other Concerns: _____

Is your child taking any medications (other than mental health medications), including over the counter and vitamins? □ Yes □ No If yes, please give name, dose, and frequency:

_____

SPIRITUALITY

Describe your family's spiritual beliefs and the role they play in your daily lives:

_____

Does your family attend church/temple/other? □ Yes, Frequency: _____ □ No

Does your child willingly attend with you? □ Yes □ No Religious Affiliation: _____

TRAUMA HISTORY

Has your child ever been verbally, physically, or sexually abused? □ Yes □ No □ Suspected

Specify: _____

Other stressors or traumas:

_____

_____

SYMPTOMS

Check any issues your child has:

□ Anger
□ Anxiety
□ Acts Out Sexually
□ Conduct Problems
□ Controlling
□ Has Unusual Sex Knowledge
□ Defiance
□ Depression
□ Homicidal Thoughts/Action
□ Dissociates
□ Hyperactivity
□ Head banging
□ Impulsive
□ Masturbates Excessively
□ Hypervigilance
□ Impaired Conscience
□ Lack of Empathy
□ Legal Problems
□ Plays Out Sexual Themes
□ Lack of Motivation
□ Lethargy
□ Plays Out Violent Themes
□ Low Self-Esteem
□ Lying
□ Nightmares
□ Night Terrors
□ Obsesses
□ Suicidal Thoughts/Actions
□ Self-Harm/ Cutting
□ Peer Problems
□ Phobias
□ Running Away
□ Shy
□ Startles Easily
□ Stealing
□ Tantrums

SUBSTANCE USE

List any substances your child has tried or you suspect they have tried:

_____

_____

SOCIAL BEHAVIOR

Does your child (check all the child **DOES**):

- ☐ Gets along w/ other kids
- ☐ Engages in imaginative play
- ☐ Gets along w/ adults
- ☐ Has friends
- ☐ Keeps friends
- ☐ Understands gestures
- ☐ Has a good sense of humor
- ☐ Understands social cues
- ☐ Uses sarcasm
- ☐ Gives into peer pressure

THERAPUETIC GOALS

What are the current concerns? Please list in order of importance:

1. _____
2. _____
3. _____

How has the family attempted to deal with these concerns? List the 3 most common methods:

1. _____
2. _____
3. _____

What are the strengths of this child/adolescent?

1. _____
2. _____
3. _____

In what situations or circumstances is this child/adolescent most likely to experience difficulty?

1. _____
2. _____
3. _____

What are your child's favorite activities, hobbies, and how do they spend their free time?

_____

Briefly, what are your goals for your child's therapy? How will you know when we have reached those goals?

_____

_____

_____

Printed name of the person completing form & Relation to Child: _____

Signature: _____ Date: _____