LISA BARBER, M.ED., LICENSED PROFESSIONAL COUNSELOR
CHILD/ADOLESCENT THERAPEUTIC INTAKE

Today's Date_____ Whom may we thank for referring you to our office? _____

Child/Adolescent Name: _____ Birthdate: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip Code:_____
Home Ph#: _____ Work Ph#: _____ Cell Ph#: _____

Whom may we contact in case of emergency: Name _____Relationship_____
Address _____
Phone # _____

Name of Insurance: _____ Member/Policy/Subcriber ID#: _____
Group #: _____

Email address if you would like to be contacted for administration purposes:_____

GENERAL INFORMATION ON CHILD/ADOLESCENT:
Mother's Name _____ Age____ Address/Phone # same as above: Yes/No
If not: Current Address_____ City_____ State____ Zip_____
Home Ph#_____ Work Ph#_____ Cell # _____
Father's Name _____ Age____ Address/Phone # same as above: Yes/No
If not: Current Address_____ City_____ State____ Zip_____
Home Ph#_____ Work Ph#_____ Cell #_____
Step Parent(s)/Legal Guardian: Name(s)_____Age(s)_____
Address/Phone # same as above: Yes/No
If not: Current Address_____City_____ State____ Zip_____
Home Ph#_____ Work Ph#_____ Cell #_____

Child's Physician: _____ Phone#_____
Has your child ever been tested by a psychologist? Yes/No If yes, please give date and reason:
_____
Has your child ever been placed in a psychiatric hospital? Yes/No If yes, please give date and reason:
_____
Is your child currently in therapy/counseling? Yes/No
Has your child received therapy/counseling in the past? Yes/No
If yes, to either of the above, please fill out the following information: Reason_____
Name of therapist/counselor: _____Date/Length of treatment_____
Has your child previously taken any medications for emotional/behavioral problems? Yes/No
If yes, please describe:_____

FAMILY DYNAMICS:
People currently living in the home:
Name:_____Age:_____ Relationship to the child:_____
Name:_____Age:_____ Relationship to the child:_____
Name:_____Age:_____ Relationship to the child:_____
Name:_____Age:_____ Relationship to the child:_____

EDUCATION INFORMATION:
Is your child currently enrolled in school/daycare? Yes/No
How many schools daycares has your child attended in the last year? _____
Name of school/daycare: _____ Grade: _____ Name of Teacher: _____
Describe your child's academic performance over the past school year: GOOD FAIR POOR
If POOR, please explain: _____
Is your child's behavior a problem in his/her school? Yes/No If yes, please describe:_____

HEALTH INFORMATION ON CHILD/ADOLESCENT:
Does your child have any chronic illnesses, genetic illnesses, allergies or handicaps? Yes/No
If yes, please describe:_____
Is your child currently being treated for any illnesses? Yes/No If yes, what type_____
Is your child taking any medication at this time? Yes/No If yes, what kind_____

Was your child born with a low birth weight? Yes/No
Was your child premature? Yes/No
Was your child exposed to prenatal drug use? Yes/No If yes, what kind_____

When did your child first:
Babble_____ Sit Unassisted_____ Become Toilet Trained_____
Roll Over_____ Walk _____
Crawl_____ Talk_____

RELATIONSHIPS:
Are the child's biological parents:
___Married/living together How long married/living together_____
___Separated/Divorced How long separated/divorced_____ Age of child at time of separation/divorce _____
Are the child's biological parents still living? Yes/No If No, age of child when parent died_____
Length of relationship with step-parent/legal Guardian _____

Describe the following relationships:
Mother and child:_____
Father and child:_____
Siblings and child:_____
Step Parent/Legal Guardian (or other significant relationships) and child:_____

BEHAVIORAL INFORMATION:
Have there been any significant events in your child's life in the past 12 months? Yes/No
If YES, please explain:_____
Describe your child's fears:_____
How does your child show affection?_____
How does your child show anger?_____
What are some of your child's favorite activities?_____

DISCIPLINE TECHNIQUES:
Mother:_____
Father:_____
Step Parent/Legal Guardian:_____

ABUSE INFORMATION:
As far as you are aware, has your child/adolescent been abused:

Physically? Yes/No If Yes, Date:_____ was CPS notified? Yes/No Date:_____
CPS Case #_____ Child's age at the time of the incident_____
Who did your child first tell about the incident?_____
Name of Perpetrator_____
Please describe:_____

Sexually? Yes/No If Yes, Date:_____ was CPS notified? Yes/No Date:_____
CPS Case #_____ Child's age at the time of the incident_____
Who did your child first tell about the incident?_____
Name of Perpetrator_____
Please describe:_____

Emotionally? Yes/No If Yes, Date:_____ was CPS notified? Yes/No Date:_____
CPS Case #_____ Child's age at the time of the incident_____
Who did your child first tell about the incident?_____
Name of Perpetrator_____
Please describe:_____

Neglect? Yes/No If Yes, Date:_____ was CPS notified? Yes/No Date:_____
CPS Case #_____ Child's age at the time of the incident_____
Who did your child first tell about the incident?_____
Name of Perpetrator_____
Please describe:_____

What was your child's reaction to the abuse/investigation/outcome:_____
_____

STRENGTHS/LIMITATIONS:
Describe your child's strengths:
_____
Describe your child's limitations:
_____

** Why have you decided to seek counseling at this time?_____
_____

I authorize this office to release information necessary to expedite insurance claims. I authorize payment to LISA BARBER, M.ED., LP for the services described on the submitted claim forms. I understand that I am responsible for payment of services not covered by the designated insurance company. I also understand that I am responsible for any charges incurred if I fail to cancel a scheduled appointment without 24 hours advance notice.

Parent or Legal Guardian's Signature:_____ Date: _____

- Abuse-emotional
- Abuse-neglect
- Abuse-physical
- Abuse-sexual
- Aggression
- Alcohol
- Anger
- Anxiety
- Arguing
- Attention problems
- Caffeine
- Career concerns
- Childhood issues (your own childhood)
- Children-care
- Children-custody
- Children-management
- Choices I have made
- Codependence
- Compulsive spending
- Concentration problems
- Confusion
- Crying
- Deaths
- Debt
- Decision making
- Decreased energy
- Delusions (false ideas)
- Dependence
- Depression
- Distracted
- Divorce
- Drugs
- Eating-making myself vomit
- Eating-overeating
- Eating-under eating
- Emptiness
- Excessively worried
- Failure
- Fatigue
- Fears
- Financial problems
- Friendship problems
- Gambling
- Grieving
- Guilt
- Headaches
- Health
- Hopeless
- Hostility
- Impulsive spending
- Impulsiveness
- Indecision
- Inferiority feelings
- Inhibitions
- Interpersonal conflicts
- Irresponsibility
- Irritability
- Judgment problems
- Laziness
- Legal matters
- Loneliness
- Loss of control
- Low frustration tolerance
- Marital conflict
- Marital infidelity/affairs
- Medical Concerns
- Mood Swings
- Nicotine
- Obsessions
- Outbursts
- Oversensitive
- Overwhelmed
- Panic/Anxiety attacks
- Parenting
- Paranoid
- Perfectionism
- Phobias
- Physical pain
- Relationship problems
- Re-marriage
- Sadness
- Self cutting
- Self control
- Self-esteem
- Separation
- Sexual conflicts
- Shyness
- Sleep-nightmares
- Step-parenting
- Stress
- Suicidal thoughts/prior attempts
- Temper problems
- Violence
- Weight and diet issues
- Withdrawal, isolating self
- Worthlessness

Any other concerns?

_____