Annie Hotchkiss, LICSW, 5 Noble Ave, 1st Floor, Westfield, MA, 413-297-5564

Child or Adolescent Intake

Please print clearly and leaving nothing blank. Thank you.

Child's name _____ Nickname_____ Date of Intake _____

Date of Birth _____ Sex M___ F____ if applicable: Trans: M to F _____ Trans F to M _____

Name of person completing this form _____ Relation to child_____

Address _____

Parent #1 –relationship to child ___Biological parent ___relative ___ guardian ___step-parent ___adoptive parent

Parent's name _____
Occupation_____
Address _____
D.O.B. _____ Age _____ Sex _____Culture_____
Best phone# or numbers to reach _____

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Parent #2 –relationship to child ___Biological parent ___relative ___guardian ___step-parent ___adoptive parent

Parent's name _____
Occupation_____
Address _____
D.O.B. _____Age _____Sex _____Culture _____
Best phone# or numbers to reach _____

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<u>IMPORTANT:</u> If parents are divorced and child moves between more than one home, **please summarize the current arrangement and provide me with a copy of the custody agreement. I must have this before I can proceed with treatment.**

_____
_____
_____
_____

Step-parents
Parent #1 remarried when_____ to whom _____
Step-parent occupation_____
D.O.B. _____ Age _____ Sex _____Culture_____
Best phone# or numbers to reach _____

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Parent #2 remarried when_____ to whom _____
Step-parent occupation_____
D.O.B. _____ Age _____ Sex _____Culture_____
Best phone# or numbers to reach _____
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Purpose of Evaluation/Treatment

Please describe the concerns you have for which you are seeking services and when they first started:

Have these concerns changes (better? Worse? Etc.) since you first noticed them? Please explain.

In what way are you hoping I can help?

Symptom Checklist

Please use initials (C for current or H for history) to identify problems or concerns with:

___fears	___stomach/bowel	___sexual	___clumsy	___separation/divorce
___panic attacks	___concentration	___temper	___slow	___step-family
___shyness	___headaches	___temper outbursts	___attention span	___running away
___loneliness	___sleep	___low self-esteem	___distractible	___rocking
___restlessness	___irritable	___drugs	___undependable	___fire setting
___guilt	___memory	___self-control	___peer conflict	___stealing
___friends	___energy	___certain thoughts	___impulsive	___lying
___anger	___grief	___suicidal	___stubborn	___school performance
___nightmares	___withdrawn	___daydreaming	___disobedient	___truancy
___crying spells	___shy	___lacks initiative	___infantile	___bed-wetting
___unhappiness	___self-mutilating	___making decisions	___mean to others	___soiled pants
___stress	___cutting body	___money	___destructive	___eating problems
___weight	___head banging	___appetite	___legal issues	___sickly

Other symptoms not mentioned above:

Please describe any prior counseling your child has had (include dates and name of therapist if possible):

Therapist name	Age of child	Type of therapy	Childs response

Past and present prescribed psychiatric medications (including sleep aids, over the counter products, herbals)

Drug name	Prescriber	Dose	How long	Results

Please list all recreational drugs your child has used or experimented with: (Please include alcohol and nicotine)

Drug name	Ages	How long	Amount/frequency

Please describe any changes that are currently or recently gone on within your child's life or family's life.

Were there any stresses or complications during pregnancy for parents or child? Please describe:

Does your child have any medical/mental health conditions or diagnoses? If so, explain:

Please list any conditions your child has and medications they are (prescription or over the counter) taking for them:

Medical Condition	Prescription or over the counter medications	Dosage & times per day	Prescriber and/or parent who administers

Please list all Allergies:

_____

_____

Has child ever been hospitalized? ___ No ___Yes, Please explain:

Who is your child's Pediatrician? _____ Phone _____

Office address _____

Child's Educational History

Did your child attend preschool? If so, where?

Have there been any school changes mid year? If yes, explain:

List elementary school/s _____

Middle school/s_____

High School/s _____

Did child skip a grade? ____No ___Yes, If yes explain:

Please describe any special awards or honors they have earned?

Repeat a grade? ___No ___Yes If yes, please explain:

Does your child have specific learning issues?

Do they have a 504 plan? ____No ____ If Yes, what are the accommodations?

Do they have an IEP plan ____No ___Yes, what are the accommodations?

Describe your child's strengths and areas of need in learning:

Does your child participate in extracurricular activities? ___No ____ Yes, list what they are:

If your child has had any specialized testing, such as educational, psychological, vocational, or hearing, etc. I would like you to bring in a copy of the test results. Briefly describe what tests were given and the results as you understand them.

Family Information

Please name every person and animal living in the home:

Name	Age	Relationship to client	Please leave blank, I will ask details

Please list any family members who are no longer living at home:

Name	Age	Relationship to client	Please leave blank, I will ask details

Mental Health of Family Members: (*excluding child coming in for services*)

Persons name relationship to child type of illness when dx type of treatment?

1. _____
2. _____
3. _____
4. _____
5. _____

Thank you for taking the time to complete this form. It is very useful to have this background information about your child and family to assist in providing the best care I can deliver. You are invited to update me as needed. If there is information I have not asked but you feel is important that I know in order to treat your child, please include on a separate paper/s and return with this intake.