Fitzpatrick & Watson Counseling, LLC

CONFIDENTIAL INTAKE INFORMATION – CHILD AND ADOLESCENT

General Information **Date_____**

Client's Last Name: _____ First Name: _____ MI: _____

Age: _____ Date of Birth: _____ Gender: Male Female

Person Completing this form: _____ Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent(s') Cell Phone: (M) _____ (F) _____ Ok to leave voicemail: yes no

Parent(s') Home Phone: (M) _____ (F) _____ Ok to leave voicemail: yes no

Parent(s') Work: (M) _____ (F) _____ Ok to leave voicemail: yes no

Parent(s') Email: _____

Authorization is granted to send email: yes no _____

School/Daycare History

Did the client ever attend daycare? Yes or No. If yes, what was their age? ____ Any problems? Please explain. _____

What school does the client attend?_____ Grade?_____

What were your child's grades on their last report card? _____

Has the client ever been held back or is currently in jeopardy of not passing this year? Yes or No.

Has the client ever been suspended or expelled from school? Yes or No. If so, please list number of times and reason(s). _____

Is he or she in ___regular education or ___ special education? If special education, what grade was it initiated? _____ Does the child have an IEP? Yes or No.

Was the child evaluated through their _____ school or _____ from another agency? If so, when, what school or agency? _____

Does the client receive any 504 accommodations? Yes or No. If so, what services?

____ preferential seating ____ test in resource room ____ extra time on assignments and tests ____ after school tutoring? How often: _____

***Emergency Contact Person*_____*Relationship*_____**

***Phone #*_____ *Address*_____**

Client's Family History Information

Biological mothers' name: _____ Biological fathers' name: _____

Mother's current age: ____If deceased, her age at death: ____Client's age upon her death: ____

Father's current age: ____If deceased, his age at death: ____ Client's age upon his death: ____

With whom does the client live with currently? Mother / Father / Stepmother / Stepfather / Grandparents / Aunt / Uncle / Legal Guardian

Does the client have siblings? Yes or No. If yes, please list names, ages, and relationship and whether siblings live in the same home as the client.

Name	Age	Relationship (biological, half, step)	Lives with client? Yes/No

Other persons living in your household and relationship to the client:

_____

Was the client adopted? _____ If yes, at what age_____

Has Department of Human Resources (DHR) ever been involved with the client's family? If so, please explain. _____

Was the client ever in foster care, a group home or residential care? _____ If yes, please list age and living situation:_____

Are the client's biological parents ____divorced, ____separated, or ___were never married? If divorced or separated, at what age was the client at time: _____.

Are parents remarried? Yes or No. Please list number and dates of remarriage(s).

_____

Please explain current custody arrangement, including legal physical custody, joint custody, and/or visitation schedule.

_____

_____

Reminder: Please bring a copy of any custody papers to the initial appointment.

Developmental History

Client's birth weight: ____lbs. ____oz. Was the client a full term, healthy pregnancy? Yes or No. If no, explain: _____

Did either parent use drugs or alcohol at the time of conception? Yes or No. If yes, explain: _____

Were there any complications with the labor & delivery such as jaundice, infection etc.? Yes or No. If yes, explain: _____

Were there any problems after birth? Yes or No If yes, explain: _____ _____

Pre-school/Toddler Temperament: Please check the following items that apply.

	Did not enjoy being held		**Feeding Problems**		**Colic**
	Excessive Restlessness		**Sleep Problems**		**Head-banging**
	Sensitive to light / noise / texture		**Fussy or unhappy**		**Difficulty bonding**

Unusual Behaviors/Speech patterns:

	Putting things in the mouth		**Saying "I" for "You"**		**Spinning**
	Repeating words or phrases inappropriately		**Sniffing excessively**		**Hand flapping**

Has there ever been any past concerns about the client's fine motor skills (i.e, holding a bottle, pencil or cutting with scissors) or gross motor skills (running, climbing, jumping)? Yes or No. If yes, please explain. _____

Has the client ever attended physical or occupational therapy? Yes or No. If yes, where and when: _____ Still receiving services? Yes or No.

Has the client ever attended speech therapy? Yes or No. If yes, what age or grade, where, and when: _____ Still receiving services? Yes or No.

Current Appetite and Sleep Patterns

How would you describe the client's appetite: good / fair / poor. Recent appetite changes? Yes or No.

Is bedtime ___ problematic or ___ nonproblematic for client? Bedtime is established at: _____.

How long client takes to fall asleep: _____ Time he/she wakes up at _____ .

Does client have: ___ Trouble winding down ___ Frequent awakening ___ Difficult to rouse

___ Appears tired/sluggish in A.M. ___ Appears well rested

Social Functioning

Does client make and maintain friendships easily? Yes or No.

Does client have a few friends and/or is uncomfortable in social situations? Yes or No.

Is he/she often "bossy" or controlling with peers? Yes or No.

Is client frequently physically aggressive with peers. Yes or No.

What are the client's preferred play and leisure activities (i.e. sports, video games, hanging out with friends, etc.)? Please list. _____.

Medical History

Name of Pediatrician or Family Doctor:_____ Phone #: _____

Current Medications (Please list all of your child's current medications):

Medication(s)	Dosage	Reason for taking	Date Initiated/ Duration	Prescribed by	Effective? (yes/no)

Please list any over the counter medications, vitamins, or herbal supplements child is taking:

_____

Please list any medication(s) that were *previously* prescribed.

Medication(s)	Dosage	Reason for taking	Date Initiated/ Duration	Prescribed by	Effective? (yes/no)	Side Effects?

Physical Health Information

Please answer the following questions using:

5- Excellent, 4- Good, 3- Average, 2- Poor, 1- Failing

How would you currently rate the client's physical health:_____

How would you currently rate the client's mental health:_____

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed. Check all that apply. ***(Please enter <u>date of onset</u> inside the box that applies.)***

	Asthma		**Allergies**		**Headaches**		**Seizures**		**Epilepsy**
	Head/Brain Injury		**Sleep Disorder**		**Hearing Problems**		**Breathing Problems**		**Immune System Problems**
	Weight Problems		**Juvenile Diabetes**		**Cancer**		**Chronic Fatigue Syndrome**		**Sexually Transmitted Disease**
	Surgeries		**Digestive Disorders**		**Blood Disorders**		**Heart Problems**		

Other illnesses: Please explain. _____

Please indicate substances used by the <u>client over the past six months</u>, how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	Current	Amount	Frequency	Length	Past use	Age
Caffeine						
Alcohol						
Diet Pills						
Tobacco						
Marijuana						

Other drugs: Please explain _____

Have you ever believed the client's substance use was a problem?_____

Has the client ever had problems with school/work, relationships, or the law due to his/her substance use?_____ If yes, please describe:_____

Has the client ever participated in drug and/or alcohol treatment?_____

If yes, please list type, length, dates, and age at time of services._____

_____

<u>Mental Health Information</u>

Date of Most Recent Illness/Symptom or issue for which the client is currently seeking counseling:
_____

Has the client previously had the same or similar symptom(s)? Yes or No. If yes, give first date:
_____

Please check any of the following symptoms or complaints that apply to your situation:

	Sad mood most days		**Low Energy/ chronic fatigue**		**Hopelessness**		**Worthlessness**		**Guilt**
	Crying Spells How many times a day/week/ month?		**Decreased motivation/ apathy (I don't care attitude)**		**Loss of interest in usual activities What activities?**		**Loss of concentration or memory difficulties**		**Irritability most days**
	Loss, decrease, or increase of appetite		**Social isolation/ withdrawal**		**Difficulty staying asleep/falling asleep**		**Excessive sleeping How many hrs a day?**		**Early morning awakenings**
	Racing thoughts		**Elevated mood**		**Excessive Worrying or feeling anxious**		**Panic Attacks What symptoms?**		**Fear of situations or things?**
	Fear of leaving home		**Fear of embarrassing oneself in public**		**Intruding or repetitive/ upsetting thoughts**		**Being orderly or a perfectionist**		**Rebellious or defiant behaviors**
	Promiscuity/ sexually acting out		**Binging/purging, or restricting food**		**Victim of physical abuse**		**Victim of sexual abuse**		**Victim of emotional abuse**
	Witness to Domestic Violence		**Peer Relationship Problems**		**Family Relationship Problems**		**School Problems**		**Legal Problems**
	Hyperactivity		**Impulsiveness**		**Inattentiveness**		**Distractibility**		**Excessive anger or aggressiveness**

Has the client ever or is he/she currently engaging in self-harm? Currently:____Past____

Has the client ever contemplated harming another person? Currently____ Past____

Has the client ever or is he/she currently contemplating suicide? Currently:____Past____

Has the client ever attempted suicide? Yes or No. If yes, please list date(s), method(s), and his/her age at the time of attempt. _____

Has anyone in the client's family ever attempted suicide? Yes or No. If yes, please list relationship(s)

_____

Has anyone in client's family ever completed suicide? Yes or No. If yes, please list relationship(s)

_____

Is the client currently receiving mental health services? Yes or No. If yes, please list name and address of practitioner and type of services:

_____

Has the client ever been diagnosed with a mental illness? Yes or No. If yes, please list illness(es) and date(s) first diagnosed, and physician or practitioner's name:

_____

Has the client ever been hospitalized for mental health concerns? Yes or No. If yes, list location, date(s) and length of stay._____

Client's Family Mental Health Background

Is there any history of the following in the client's family? (Family includes parents, siblings, paternal or maternal grandparents, aunts, uncles, and/or cousins)

Depression **Yes ____** **No____** **Family Member(s) with Condition_____**

Anxiety **Yes ____** **No____** **Family Member(s) with Condition_____**

Bi-polar **Yes ____** **No____** **Family Member(s) with Condition_____**

Schizophrenia **Yes ____** **No____** **Family Member(s) with Condition_____**

Drug Abuse **Yes ____** **No____** **Family Member(s) with Condition_____**

Alcoholism **Yes ____** **No____** **Family Member(s) with Condition_____**

Learning Disabilities **Yes ____** **No____** **Family Member(s) with Condition_____**

ADD/ADHD **Yes ____** **No____** **Family Member(s) with Condition_____**

Other **Yes ____** **No____** **Family Member(s) with Condition_____**

Please indicate if a member of the client's immediate family has experienced any of the following:

	Emotional Abuse		**Legal Problems**
	Physical Abuse		**Frequent/Multiple Moves**
	Sexual Abuse		**Homelessness**
	Domestic Violence		**Financial Problems**
	Neglect		**Lived over-seas**
	Military Member		**Serious Illness**
	Accident or Injury		**Child Rearing Problems**
	Other		**Other**

I acknowledge that I am voluntarily consenting to counseling and that no guarantees have been made as to the results of counseling.

Signature_____ **Date_____**

Parent/Guardian

Signature_____ **Date_____**

Client (if 14 years old or older)