Child and Adolescent Intake Form

Personal Information

Client Name: _____ Date of Birth/Age: _____ SSN: _____

Sex: Female Male Transgender M to F Transgender F to M Other _____

Mother's Name: _____ Father's Name: _____

Parents are: married/divorced (circle one) I live with (which parent):

Street Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Is it okay to leave a message? Yes No

Cell Phone: _____ Is it okay to leave a message? Yes No

Email Address: _____ May we e-mail you? Yes No

In an emergency, who do we call? Contact Name: _____ Contact Phone: _____

Religious Affiliation (if any): _____

Insurance Information

Name of Insurance Company:_____

Insurance Co. Phone # (Mental Health):_____

Policy Owner's Name:_____ Policy Owner's Date of Birth:_____

Policy Owner's SS#: _____

Insurance ID #:_____ Policy or Group#:_____

Policy Owner's Address (only if different than above):_____

Please be prepared to provide our office staff with your insurance card so that we may make a copy.

Presenting Problem

What brings you here today? (please be as specific as possible)

_____

_____

_____

Mental Health History/Information

Please circle all that apply to your child (choose severity that applies).
(0) Not Present, (1) Mild, (2) Moderate, (3) Severe

Depression	**0 1 2 3**	Memory Problems	**0 1 2 3**	Panic Attacks	**0 1 2 3**
Anxiety	**0 1 2 3**	Loss of Interest	**0 1 2 3**	Obsessive Thoughts	**0 1 2 3**
Mood Swings	**0 1 2 3**	Irritability	**0 1 2 3**	Ritualistic Behavior	**0 1 2 3**
Appetite Changes	**0 1 2 3**	Excessive Worry	**0 1 2 3**	Checking	**0 1 2 3**
Sleep Changes	**0 1 2 3**	Suicidal Ideation	**0 1 2 3**	Counting	**0 1 2 3**
Hallucinations	**0 1 2 3**	Relationship Issues	**0 1 2 3**	Self-Injury	**0 1 2 3**
Racing Thoughts	**0 1 2 3**	Low Energy	**0 1 2 3**	Difficulty with	**0 1 2 3**
Confusion	**0 1 2 3**	Hyperactivity	**0 1 2 3**	Concentration	

Describe a brief history of your child's present symptoms:

_____

_____

What effect have they had on your child's life?:

_____

_____

Has your child ever been diagnosed with a mental health disorder? If yes, please describe:

_____

_____

Has your child ever been treated for a mental health problem? If yes, please describe:

_____

_____

Has your child ever had a mental health hospitalization? If yes, please describe:

_____

_____

Substance Use

To the best of your knowledge, does your child currently use any substances (i.e., tobacco, alcohol, marijuana, etc.)? ___ No ___ Yes

If yes, please provide the name of the substance(s), frequency, and amount of use:

_____

_____

Family Information

Where was the child born? _____

How long has the child lived where they are now? _____

Are the child's parents married? ___ No ___ Yes
If not, when did they divorce/separate?_____

Who does the child live with? (list all people within the home – name, relationship, age):

_____

_____

_____

_____

Describe the family in which your child is being raised:

_____

_____

How does your child get along with members of the family?

_____

_____

Is there any other family information that you want the counselor to know?

_____

_____

Is there a history of mental health or substance abuse problems in your family? ___ No ___ Yes
If yes, please explain:

_____

_____

_____

_____

Has your child experienced any physical, emotional, or sexual abuse? ___ No ___ Yes
If yes, please explain:

_____

_____

Are there any guns or weapons in your home? _____ No _____ Yes
If yes, specify what type and where gun/weapon is stored:

_____

List/describe anything else you'd like us to know about your child's family and/or home life:

Medical History/Information

Previous Surgeries/Major Illness or Injury/Medical Diagnoses (please include reason and year):

_____

_____

Please list any additional health information that may be important for the counselor to know (including any medication or other allergies):

_____

_____

List daily medications and dosages (including over the counter medications)

Current Medication	Dosage	Prescribing Physician	Last Dose	Taking as Prescribed?

Is your child having any difficulty with pain? ___ No ___ Yes; please describe:

_____

_____

Has your child ever: Binged on food? _____ Gone without eating? _____

Vomited on purpose? _____ Used laxatives to purge? _____

Educational History

What school or daycare does your child attend, and in what grade?

_____

Does your child currently receive special education services? ___ No ___ Yes; please explain:

_____

_____

Did either parent have any learning or behavioral issues in school? ___ No ___ Yes; please explain:

_____

_____

Describe your child's attitude toward school: _____

Described your child's grades in school: _____

Has your child ever been held back a grade? ___ No ___ Yes; please explain:

_____

Has your child ever been tested for intellectual disabilities? ___ No ___ Yes; please explain:

_____

Has your child ever been tested for learning disabilities? ___ No ___ Yes; please explain:

_____

Do you have any educational concerns for your child at this time? ___ No ___ Yes; please explain:

_____

_____

_____

_____

List/describe anything else you'd like us to know about your child's education:

Developmental History/Behavior Concerns

Please identify any complications that occurred during pregnancy, delivery, or immediately after the birth of your child:

_____

_____

_____

_____

Please describe the development of your child during early childhood --

Motor Milestones (crawling, walking, running): ___Normal, ___Delayed (please explain):

_____

_____

Cognitive Milestones (thinking, learning, problem solving): ___Normal, ___Delayed (please explain):

_____

_____

Self-Help Milestones (eating w/spoon, using sippy cup): ___Normal, ___Delayed (please explain):

_____

_____

Social/Emotional Milestones (understanding emotions): ___Normal, ___Delayed (please explain):

_____

_____

Speech/Language Milestones (talking): ___Normal, ___Delayed (please explain):

_____

_____

Does your child regularly engage in social activities? ___ No ___ Yes

Does your child regularly build positive social relationships? ___ No ___ Yes

What are your child's hobbies or leisure activities?

_____

_____

Please describe your child's personality:

_____

_____

_____

_____

Do you have any concerns regarding your child's behavior at this time? ___ No ___ Yes; please explain:

_____

_____

_____

_____

Does your child have any past or current involvement with the legal system? ___ No ___ Yes; please explain:

_____

_____