Child/Adolescent Intake Information

The following information is designed to support your child's treatment. The information provided in these forms will be stored in your child's clinical file and handled as a confidential document.

Please fill this form out to the best of your ability. If you aren't sure how to answer a question, leave it blank and discuss it with your counselor.

General Information:

Child's Name: _____ _____ _____
(Last) **(First)** **(MI)**

Parent(s) Name(s): _____

Child's Birth Date: _____ / _____ / _____ **Child's Age:** _____ **Child's Gender:** ☐ **Male** ☐ **Female**

How did you hear about us? _____

Home Address: _____**City:** _____**State:** _____ **Zip:** _____

Email: _____

Primary Phone: _____ - _____ - _____ **May we leave a leave message?** ☐ **yes** ☐ **no**

Alternate Phone: _____ - _____ - _____ **May we leave a leave message?** ☐ **yes** ☐ **no**

Emergency Contact: _____ **/ tel.** _____ - _____ - _____

Educational History:

What school does your child attend:	Teacher's name:	Child's current grade: (circle one) N/A Pre K 1 2 3 4 5 6 7 8 9 10 11 12
Has your child ever repeated a grade? ☐ Yes ☐ No If so, which one:	Child's favorite subject:	Child's least favorite subject:
Does your child receive special education services, have an IEP or 504: ☐ Yes ☐ No	Does your child receiving tutoring: ☐ Yes ☐ No If yes, which subjects:	Is your child in the gifted, talented or honors program: ☐ Yes ☐ No
Does your child like school: ☐ Yes ☐ No	Does your child have friends: ☐ Yes ☐ No	Does your child get in trouble often: ☐ Yes ☐ No

Has your child experienced any of the following: (check all that apply)

☐ fighting ☐ suspension ☐ gang influence ☐ learning disabilities ☐ incomplete homework ☐ drugs/alcohol
☐ poor attendance ☐ behavior problems ☐ detention ☐ poor grades

Has your child been the victim or bullying or bullied other children: ☐ Yes ☐ No
If yes, please explain:

Please provide any additional information regarding your child's education or developmental history that you find significant:

Medical History:

List of medications that your child is currently using:

Rx Medication	Dosage	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTC Medication	Dosage	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pediatrician's Name: _____ tel. _____

Psychiatrist's Name: _____ tel. _____

List any illnesses or disabilities your child has been diagnosed with:	
Illness/Disability:	Date of Diagnosis:

Is your child *currently* seeing another therapist/counselor: □ Yes □ No If yes, who are you seeing:			
Has your child ever had a psychiatric hospitalization: □ Yes □ No If yes, briefly describe including dates and circumstances:			
Has your child been to therapy in the past: □ Yes □ No If yes, please fill out the following related to previous counseling experience(s):			
Therapist name:	Location:	Dates:	Reasons:

Current Concerns:

Concerns (Check the items that apply to your child):

□ Depression	□ Stress	□ Trouble focusing	□ Past physical abuse
□ Low energy	□ Anxiety/ worry	□ Restrictive Eating	□ Present physical abuse
□ Low self-esteem	□ Panic attacks	□ Binging/Purging	□ Past sexual abuse
□ Poor concentration	□ Physical Symptoms	□ Body Image	□ Current sexual abuse
□ Hopelessness	□ Moodiness	□ Picky Eating	□ Past trauma
□ Lying	□ Lack of friends	□ Risky sexual behavior	□ Recent trauma
□ Guilt	□ Being Bullied (victim)	□ Delusions	□ Nightmares
□ Sleeping too much	□ Bullying (perpetrator)	□ Hallucinations	□ Easily startled
□ Sleeping too little	□ Shy/Timid	□ Alcohol/Drug Use	□ Flashbacks
□ Thoughts of hurting self	□ Fears	□ Talking Back	□ Hyperactivity
□ Thoughts of hurting others	□ School Problems	□ Difficulty speaking	□ Low interest in activities
□ Isolation/ withdrawal	□ Easily agitated	□ Toileting issues	□ Avoiding people & places
□ Feelings of sadness	□ Obsessive thoughts	□ Anger/ Frustration	□ Separation Anxiety
□ Grief/ loss	□ Compulsive behaviors	□ Conflict with others	□ Feeling out of sorts

Other concerns that are not listed above?

_____

_____

Please rate your estimation of your child's current level of concern or stress on a scale from 0-10, 0 being no distress and 10 being extremely distressed. (circle one)

0 1 2 3 4 5 6 7 8 9 10

Other History:

Have you or your child experienced any type of abuse: (physical, sexual or emotional) □ Yes □ No
If yes, please describe:

Has your child ever made a statement about wanting to hurt him/herself or seriously hurt someone else? □ Yes □ No
If yes, please describe:

Has your child ever experienced any serious emotional losses: (such as the death or physical separation from a parent, caregiver or good friend) □ Yes □ No
If yes, please describe:

Are there any behaviors your child does too often, too much or at the wrong times that gets him/her in trouble: □ Yes □ No
If yes, please describe:

Are there any behaviors that your child fails to do as often as you would like or when you would like: □ Yes □ No
If yes, please describe:

Please list positive strength of your child: (what do you like about your child, what do others like)

How would you describe your child's self-esteem:

Briefly describe your reasons for seeking help at this time:

What goals do you wish to accomplish during this therapy process as a parent:

What does your child wish to accomplish during this therapy process: (it is okay for child goals to be different than parent goals)

Family History:

Mother's name: Occupation:		Father's name: Occupation:	
Child's parents are: □ Married □ Separated □ Divorced □ Widowed Dates of divorce, separation, death:			
Step-Mother: □ Yes □ No Name:		Step-Father: □ Yes □ No Name:	
Who does your child currently live with:			
Names:	Age:	Relationship to Child:	Grade/Job

Who in the family is your child closest to:

What are some strengths of your family?

Does anyone in the child's family use currently (or ever in the past) any type of drug, tobacco or alcohol: □ Yes □ No

If yes, please describe:

Has anyone in the child's family been diagnosed with a chronic or mental illness: □ Yes □ No

If yes, please describe:

Anything else that you think would be important for me to know about your child, you or your family:

Parent Signature: _____ **Date: _____**

Therapist Signature: _____ **Date: _____**