Clarke Counseling & Psychological Services

CONFIDENTIAL

Child/Adolescent Intake Form

Client First and Last name: ____ Today's Date: ___________________

Client Date of Birth: ___________________ Age: __________ Male: _____ Female: _____ Transgender: ____

Name of Person Completing this form other than client: ____

Your relationship to child ____

Home Address: ____
Street

____
City State Zip

Home Phone: _____________________________ Is it OK to contact you at home? ___ OK to leave a message? _______

Cell Phone: ______________________________ Is it OK to contact you on your cell? ___ OK to leave a message? _______

Email address: __________________________________ Who referred you? _______________________________

Parents are: □ Single □ Married □ Separated □ Divorced □ Remarried □ Widowed □ Cohabitating

If divorced, does other parent have: □ Sole Custody □ Shared Custody □ Visitation □ Supervised Visitation □ No Visitation Rights (*Please bring copy of custody agreement for the chart*).

Please give the other parent's address and phone number.

Name:

____

Address:

____
Street City State Zip

Cellphone number: ___________________________________

Are both parents aware that the child is participating in counseling/evaluation? □ Yes □ No

Stepmother's Name: ____

Stepfather's Name: ____

Please list the reason for seeking help:

1.____

2.

____

3.

____

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How long has the problem(s) been going on? ____

What made you come in at this time? ____

What do you hope to gain from this evaluation and/or counseling? ______________________________

How many people live in your household?

Name	Age	Relationship	Occupation/Grade	Does your child get along with? (Y, N)

Please indicate the symptoms that your child is currently experiencing.

	Mild	Moderate	Severe			Mild	Moderate	Severe
Aggression/Fights/Temper Tantrum					Lying			
Anxiety/Worry					Mood swings			
Alcohol/Drug use					Motor Coordination			
Aches & Pains Related to School					Manipulative Behavior			
Boredom					No/few friends			
Crying Spells					Nightmares/Night terrors			
Compulsive Behaviors					Obsessive thoughts			
Curfew Violations					Poor Memory/Confusion			
Computer Addiction					Peer/Sibling conflict			
Concerned about illness					Panic Attacks			
Distractibility					Racing Thoughts			
Defiance					Running away			
Destroys Property					Recurring, disturbing memories			
Difficulty with Authority								
Eating problems					Sadness/Depression			
Fatigue					Suspicion/Paranoia			
Fire setting					Self-harm thoughts/ behaviors			
Hearing Voices					Swearing			
Hyperactivity					Stealing			
Hopelessness					Sleep problems			
Impulsivity					Social Discomfort			
Irrational/Excessive Fears					Sexual Behavior			
Inattentive					Separation Anxiety			
Irritability/Anger					Toileting problems			
Lack of Motivation					Trauma/Loss			

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	Mild	Moderate	Severe			Mild	Moderate	Severe
Legal problems					Visual Hallucinations			
Language/Speech Difficulties					Withdrawal			
Loneliness					Work/School Problems			
Low Self Worth					Worthlessness			

Are the above-mentioned problems affecting any of the following? (check all that apply)

□ Handling everyday tasks
□ Relationships
□ Self-esteem
□ Hygiene
□ Health
□ Recreational activities
□ Work/School
□ Housing
□ Legal matters
□ Finances
□ Other: Please Specify ______________________________

What have you done to address any of the above concerns and how effective were these efforts?

____

Has your child ever had thoughts, made statements, or attempted to hurt him/herself? □ Yes □ No
If yes, please describe:

____

____

Has your child ever had thoughts, made statements, or attempted to hurt someone else? □ Yes □ No
If yes, please describe:

____

____

Has your child recently been physically hurt or threatened by someone else? □ Yes □ No
If yes, please describe:

____

____

Please provide any other information on the psychological history that you feel would be helpful to us in understanding your child:

____

____

____

For each item below, circle the answer that best describes your child: **0 = Not at all; 1 = Just a Little; 2 = Often; 3 = Very Ofte**					
Inattention Symptoms					
1	Fails to give attention to details or makes careless mistakes in schoolwork, work, or during other activities (e.g., overlooks or misses details, work is inaccurate).	**0**	**1**	**2**	**3**
2	Has difficulty sustaining attention to tasks or play activities (e.g., has difficulty remaining focused during lectures; conversations; or lengthy reading).	**0**	**1**	**2**	**3**
3	Does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).	**0**	**1**	**2**	**3**
4	Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked.	**0**	**1**	**2**	**3**
5	Has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized with work; has poor time management; fails to meet deadlines).	**0**	**1**	**2**	**3**
6	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).	**0**	**1**	**2**	**3**
7	Loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).	**0**	**1**	**2**	**3**
8	Is easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).	**0**	**1**	**2**	**3**
9	Is forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).	**0**	**1**	**2**	**3**
Hyperactive Symptoms					
10	Fidgets with or taps hands or feet or squirms in seat	**0**	**1**	**2**	**3**
11	Leaves seat in situations in which it is inappropriate (NOTE: in adolescents or adults may be limited to feelings of restlessness).	**0**	**1**	**2**	**3**
12	Unable to play or engage in leisure activities quietly	**0**	**1**	**2**	**3**
13	Has difficulty playing or engaging in leisure activities quietly	**0**	**1**	**2**	**3**
14	Is “on the go” or acts as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with)	**0**	**1**	**2**	**3**
15	Talks excessively	**0**	**1**	**2**	**3**
Impulsive Symptoms					
16	Blurts out an answer before question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation).	**0**	**1**	**2**	**3**
17	Has difficulty waiting his or her turn (e.g., while waiting in line).	**0**	**1**	**2**	**3**
18	Interrupts or intrudes on others (eg, butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission; for adolescents and adults may intrude into or take over what others are doing)	**0**	**1**	**2**	**3**
Approximately when did you first notice the behaviors that occur often or very often? ______________					
Do these symptoms impair your child’s functioning in two or more settings (circle all that apply) **Home School Socially Church**					

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BIRTH & DEVELOPMENT INFORMATION

Mother's health during pregnancy was: □ Good □ Fair □ Poor

Age of mother at child's birth? ______________________________

Number of pregnancies ______________________________ Number of children ________________________

Did mother use any of these substances or medications during pregnancy?

Beer/wine: □ Yes □ No
Coffee/caffeine: □ Yes □ No
Hard liquor: □ Yes □ No
Cigarettes: □ Yes □ No
Tranquilizers (Sleeping pills) □ Yes □ No

Did mother receive prenatal care, if so when? ____

Did mother eat well during pregnancy? ____

Did mother take vitamins, calcium, iron etc.? ____

Did mother have any illnesses such as flu, cold, kidney infections, diabetes, high blood pressure, seizures, or an operation during pregnancy? If so please explain

____

Did mother experience problems with vomiting, excessive weight gain, swelling, high blood pressure, infections, convulsions, or headaches? If so please explain

____

Did mother have any X-rays during pregnancy and if so when? ____

Length of Pregnancy: ______________________________ Baby was: □ early □ on time □ late

Duration of Labor: ____________________________________

Fetal distress during labor? □ Yes □ No

Was delivery: □ Normal □ Breech □ Caesarian □ Forceps □ Suction □ Induced

Child's birth weight? ________ Pounds ______________ Ounces APGAR score: ____________________

Did the baby cry and breathe immediately on his own? □ Yes □ No If No, please explain

____

Did the baby have a good suck immediately? □ Yes □ No If No, please explain ____________________________

____

Was the baby given artificial resuscitation? □ Yes □ No If Yes, please explain ___________________________

____

Was the baby kept on oxygen? □ Yes □ No If Yes, for how long ____________________________

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___

Did your baby have blue skin, nails, or lips? □ Yes □ No If Yes, please explain ____________________________

___

Did your baby have spasms, fits, or seizures? □ Yes □ No If Yes, please explain ____________________________

___

Was your baby □ breast fed or □ bottle-fed?

Did your baby have a strong cry? □ Yes □ No If No, please explain ______________________________

___

Were there any initial feeding problems in the first weeks? □ Yes □ No If Yes, please explain

___

___

How old was your baby when discharged from the hospital? _________________________________

Other comments?

___

___

Did your baby have the following:

Feeding Problems	□ Yes	□ No
Colic	□ Yes	□ No
Vomiting	□ Yes	□ No
Sleep excessively	□ Yes	□ No
Cry excessively	□ Yes	□ No
Cuddly	□ Yes	□ No

Rate the activity level of the child:

□ Very active □ Active □ Average
□ Less active □ Not active

When your child wanted something, how insistent was (s)he?

□ Very insistent □ Somewhat insistent □Average
□Not very insistent □Not at all insistent

How was it to care for your child?

□Very easy □Easy □ Average
□ Difficult □ Very difficult

How did your child behave with other people?

□ More sociable than average □ Average sociability □ More unsociable than average

How would you describe your child's approach to new situations?

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□ Positive, jumps right in □ Withdrawn, tends not to participate □ Slow to warm up; cautious

How would you generally describe your child's overall mood?
□ Positive (happy, laughing, upbeat) □ Negative (depressed, cranky, angry) □ Mixed, but more positive than negative □ Mixed, but more negative than positive

Developmental History
At what age did your child do the following? (parentheses reflect normal development)

Smiled (up to 4 months) ______________

Rolled Over (1-6 months)_______________

Sat up alone (6-10 months) _____________

Fed self with cracker _______________

Grabbed objects (3-7 months) _______________

Pulled to stand up (6-12 months) _______________

Sat Alone (6 to 10 months) _______________

Took 2-3 steps alone (9-12) _______________

Walked by Self (12 months) _______________

Bladder trained (16-36 months) ____________

Bowel trained (16-36 months) _____________

Rode bicycle_______________

Tie shoes _______________

Dress self_______________

MEDICAL HISTORY

Child's pediatrician: ____ Telephone Number: ________________

Address:
____

When was the last time your child was checked by his/her pediatrician? ______________________________________

Results
____

How would you describe your child's current health? □ Excellent □ Good □ Fair □Poor

How is his/her hearing? □ Good □ Fair □ Poor
Vision? □ Good □ Fair □ Poor
Speech and language? □ Good □ Fair □ Poor

Fine motor coordination? □ Good □ Fair □ Poor
Gross motor coordination? □ Good □ Fair □ Poor

Has your child ever had chronic health problems (e.g., asthma, diabetes, allergies, heart condition)? □Yes □ No If yes, please specify
____
____

Has your child ever been hospitalized since birth? □ Yes □ No If yes please explain:
____
____

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Does your child currently take any medications? If so what?

Current medication	Dosage & Frequency	What is it prescribed for	Prescribing Physician

Please list past medications if any and what they were prescribed for:

Past medication	What was it prescribed for	Prescribing Physician	Was it helpful?

Please indicate (with a check mark) whether your child had any of the following:

Chicken Pox		Head Injuries	
Bleeding Problems		Heart/Lung Disease	
Bad Teeth		Allergies	
Broken Bones (if yes, where)		Allergies to medication	
Bad Hearing		Asthma	
Measles		Paralysis/Weakness	
Earaches		Severe/Prolonged Headaches	
Mumps		Bronchitis	
Stomach/Abdominal Pain		Eczema	
Vomiting		Convulsions	
Ear Infection		Coughing Up Blood	
Trouble with Diarrhea		Hay Fever	
Trouble with Constipation		Poisoning	
Bloody or black stools		Hives	
Squinting of Eyes		Sleeping Problems	
Roseola		Painful/Swollen Joints	
Rheumatic Fever		Difficulty Breathing	
Speech Problems		Spells/Passing out	
Scarlet Fever		Burns	
Squinting of the eyes		Nose Bleeds	
Whopping cough		Skin Disease	
Double/Blurred Vision		Staring/Blank Spells	
Pneumonia		Kidney Disease/Infection	
Blood in Urine		Unexplained High Fevers	
Unconsciousness		Tonsillitis	
Sinusitis		Problems with urination	
Severe Injuries		Jaundice	
Tuberculosis		Operations (if yes, describe)	
Anemia		Fever Blisters	
Other (specify)			

FAMILY MEDICAL HISTORY

Check all that apply to biological family	Mother	Maternal Family	Father	Paternal Family	Siblings
Heart Disease					
Thyroid Problems					
Problems with inattention					
Hyperactivity/ impulse control					
Problems with aggression/oppositional behaviors					
Seizure Disorder					
Asthma					
Learning disabilities					
Cognitive/intellectual disabilities/Mental Retardation					
Autism Spectrum					
Anxiety					
Depression					
Obsessive Compulsive Disorder					
Eating Disorder					
Schizophrenia or Psychosis					
Bipolar Disorder					
Suicidal thoughts or attempts					
Drug abuse or dependence					
Reading Problems					
Diabetes					
Rheumatoid Arthritis					
High Blood Pressure					
Alcoholism					
Motor/Vocal Tics					
Deafness					
Cleft Palate					
Liver Disease					
Cancer					
Other (specify)					

EDUCATIONAL HISTORY

Name of Current School: ____ Current Grade: __________

Did your child attend preschool? □ Yes □ No If yes, what age did (s)he start? ______________________________

If yes, were there any problems with the following:
□ separation from parents □ aggression towards other children □withdrawal from other children
□ inattentiveness □ hyperactivity
□ impulsivity □ learning
□ fine motor skills □ or any concerns at that time? Please provide details:

____

Any teacher comments (about behavior or school readiness?)

____

____

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During Kindergarten were there any problems with:

□ separation from parents □ aggression towards other children □withdrawal from other children
□ inattentiveness □ hyperactivity
□ impulsivity □ learning
□ fine motor skills □ or any concerns at that time? Please provide details:

Any teacher comments (about behavior or school readiness?)

During 1st grade were there any problems with:

□ separation from parents □ aggression towards other children □withdrawal from other children
□ inattentiveness □ hyperactivity
□ impulsivity □ learning
□ fine motor skills □ or any concerns at that time? Please provide details:

Has your child had difficulty with spelling or reading (letter reversals, word reversals, forgetting letters and words easily, difficulty learning to spell, difficulty with words beginning with "th," "wh," "w."

Any teacher comments (about behavior or school readiness?)

Please provide the details for the following grades:

Grade	Note Significant behavior/academic/emotional difficulties	School
2nd grade		
3rd grade		
4th grade		
5th grade		
6th grade		
7th grade		
8th grade		

9th grade		
10th grade		
11th grade		
12th grade		

Has your child ever repeated or skipped a grade? If so, please describe the circumstances: ___________________________

____

Has your child ever been tested for intellectual ability or had any other psychological testing? If so, what was the most recent date of testing: ___________________________ Please describe the results: ________________________________

____

Does your child have a 504 Plan/IEP/Special Education Services? If so, please briefly describe the nature of the accommodations:

____

____

Does your child's teacher have concerns about your child? If so, please describe: _________________________________

Please list any other concerns that you have for your child related to school: _____________________________________

____

____

This year's school grades:	□ Excellent	□ Good	□ Fair	□Poor
Past school grades:	□ Excellent	□ Good	□ Fair	□Poor
This year's school behavior:	□ Excellent	□ Good	□ Fair	□Poor
Past school behavior:	□ Excellent	□ Good	□ Fair	□Poor

Has your child had any of the following difficulties at school?

□ Suspension	□ Incomplete homework	□ Learning problems
□Referrals or detentions	□ Poor grades	□ Bullied
□ Speech problems	□ Attendance problems	□ Gang influence

Throughout your child's educational history, have teachers or other educational personnel reported any of the following about your child

	Yes	No	Don't Know
Poor Reader			
Distractible			
Inattentive			
Disturbs other children			
Does not complete work			
Excessive talking			
Daydreams			
Slow in moving/responding			
Fights			
Gets out of seat without permission			
Difficulty following instructions			
Difficulty thinking of words to say			
Impulsive			
Difficulty making and keeping friends			

What is your child's attitude toward school? ____

What is your child's attitude toward reading and math? ____

Does your child have difficulty reading in public or in front of a class? □ Yes □ No

How long does your child watch television or spend time on a screen? ______________________________

What activities, special treats, or toys does your child find rewarding?

____

____

Is your child involved in any after school programs or groups in school?

____

____

SUBSTANCE ABUSE

Do you have any concerns about your child's use of alcohol or drugs? □ Yes □ No If yes, please describe

____

____

LEGAL INFORMATION

Please list any legal issues that are affecting your child or your family at present, or have had a significant effect upon your child in the past:

____

____

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PSYCHIATRIC HISTORY

Has your child ever been treated by a psychiatrist, psychologist, or mental health counselor □ Yes □ No, If yes, please describe, whom, when, for how long, and what was the focus of the treatment.

____

BEHAVIOR MANAGEMENT/DISCIPLINE

Which discipline strategies to you utilize?

□ Let situation go
□Take away something material
□ Time out
□ Assign an additional chore
□ Send to room
□ Ground child
□Take away privilege
□ Reason with child/problem-solve/negotiate
□Yell at child
□ Physical punishment

List any other techniques:

____

____

What are the main differences between mother and father in the method of discipline?

____

____

POSITIVE QUALITIES

Describe your child's positive qualities, including strengths, special abilities, and skills:

____

____

____