Tiffany Thibodeaux, LPC, NCC
Professional Counselor for Adults & Adolescents

Adolescent & Child Intake Form

To Be Completed by the Parent/Guardian

PERSONAL INFORMATION	
Name	Preferred Name
Gender	Date of Birth
Address	City/Zip
Child's Phone Number	

FAMILY INFORMATION	
Parent/Guardian #1	Relationship
Phone Number	Email Address
Parent/Guardian #2	Relationship
Phone Number	Email Address
Emergency Contact	Emergency Phone
Text Appointment Reminders? ☐ Yes ☐ No	Email Appointment Reminders? ☐ Yes ☐ No

How did you hear about Tiffany? _____

INSURANCE INFORMATION

Name of Insurance Carrier _____ Member ID #_____

Policyholder's Name _____ Policy holder's DOB _____

Name of Employer _____ Group Number _____

Our office will attempt to verify your health insurance benefits and/or necessary authorizations for you. Please be aware this is only "A Quote of Benefits/Authorizations". We cannot guarantee payment or verify the eligibility or benefits conveyed to us, or to you, will be accurate or complete. Payment of benefits are subject to all terms, conditions, and exclusions of the members' contract at the time of service. Our office will not know your exact coverage until the claim is processed and we received an explanation of benefits from your insurance company.

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Therapy Information		
Describe the reason you are seeking counseling for your child.		
How long has this problem been going on?		
Has your child experienced any major stressors in the last year*? (ex: death of a loved one, major illness, move of home or school, divorce, trauma, loss of employment, abuse, or major life change?)*		
What would you like your child to accomplish in counseling?		
List some of your child's strengths and weaknesses.		
Is your child religious or spiritual?	☐ Yes ☐ No	Religion: Level of involvement:

Mental Health History		
Conditions that your child has been diagnosed or treated for: ☐ ADD/ADHD ☐ Anxiety ☐ Bipolar Disorder ☐ OCD ☐ Depression ☐ Borderline Personality Disorder ☐ Schizophrenia ☐ Gender Dysphoria ☐ Learning Disability ☐ Other _____		
Physician Name		Year
Has your child attended counseling before today?	☐ Yes ☐ No	Reason for attendance: Therapist name: Date(s): Outcome: ☐ Successful ☐ No Change ☐ Worse
Has your child ever been prescribed psychiatric medication?	☐ Yes ☐ No	Physician name: Medications:
Has your child ever completed a psychiatric or psychological evaluation?	☐ Yes ☐ No	Reason: Physician Name: Year:
Has your child ever been hospitalized for a mental health condition, drug or alcohol abuse, an eating disorder, self-injurious behaviors, or suicidal ideation?	☐ Yes ☐ No	Reason: Name of Facility: Date(s): Outcome: ☐ Successful ☐ No Change ☐ Worse
Has your child ever attempted suicide?	☐ Yes ☐ No	Details: Date(s):
Has your child expressed thoughts of suicide?	☐ Yes ☐ No	Explain:
Does your child have problems sleeping?	☐ Yes ☐ No	☐ Problems Falling Asleep ☐ Sleeps too much ☐ Problems Staying Asleep ☐ Doesn't sleep enough

Mental Health History Continued		
Has your child experienced any traumatic events? (ex: flooding, fire, witness of a crime, deaths)	☐ Yes ☐ No	*Explain*
Does your child have any close relatives (parents, siblings, grandparents, children) who have experienced a mental health condition?	☐ Yes ☐ No	*List relationship and diagnosis*

Medical Information	
Primary Care Physician	Phone Number
List any important medical history, chronic ailments, or other health problems.	
Does your child take medication for physical or psychiatric conditions? If yes, please list medication(s) below	

Name of Medication	Dosage	Condition Treated	Prescribing Physician

List any medications that child has taken in the past.

Abuse		
Does your child drink alcohol or use illegal drugs?	☐ Yes ☐ No	Substance used?
Do any close relatives (parents, siblings, grandparents, children) who have or have had drug or alcohol abuse problems?	☐ Yes ☐ No	List relationship and substance(s) used:
Has your child ever been physically, emotionally, or sexually abused?	☐ Yes ☐ No	Details:
Is there currently abuse in their household or relationship?	☐ Yes ☐ No	Explain:

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Family Information					
Are parents' biological parents married or do they live together? ☐ Yes ☐ No					
If parents are divorced or child does not live with both biological parents, complete the following:					
Who has custody of the child?					
Amount of time spent with each parent:	Mother		Father		
Are parents remarried?	Mother ☐ Yes ☐ No		Father ☐ Yes ☐ No		
List everyone who lives in the home with the child. Include stepparents, partners, and siblings.					
House 1			**House 2**		
Name	Relationship	Age	Name	Relationship	Age
Are their any siblings who do not live with the child?					

Birth & Development	
Were than any problems with your child's Mother's pregnancy or complications at birth? Explain	☐ Yes ☐ No
Did you have any developmental delays (walking or talking), Any educational concerns? Learning disabilities? IEP/Special Education? Explain	☐ Yes ☐ No

School Information	
School Name	Grade
Average Report Card Grades: ☐ Honor Roll ☐ Average Student ☐ Failing 1 or more class(es)	
Extra-Curricular Activities/Sports:	
How does your child feel about school?	

Legal History		
Is anyone requiring your child to attend counseling?	☐ Yes ☐ No	Person, Court, or Facility:
Has your child ever been arrested, had legal charges or have pending court dates?	☐ Yes ☐ No	Dates and offense:
Has your child ever been involved with DCFS?	☐ Yes ☐ No	Explain:
Is there currently litigation involving your child's custody?	☐ Yes ☐ No	Explain:

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Parental Concerns Checklist

Check all issues that concern you about your Child

☐ Abuse or neglect	☐ Flashbacks	☐ Nightmares
☐ Academic/Grade problems	☐ Frequent headaches	☐ Obsessive behaviors or thoughts
☐ ADD/ADHD	☐ Gender issues/confusion	☐ Panic Attacks
☐ Aggressive behavior	☐ Gets into fights	☐ Phobias
☐ Alcohol/drug use	☐ Grief/loss issues	☐ Picky about textures/smells/sounds
☐ Anger problems	☐ Hallucinations	☐ Poor attention/concentration
☐ Anxiety or nervousness	☐ Has harmed animals	☐ Restless/on edge
☐ Appetite or eating problems	☐ Hates to be alone	☐ Risk Taking Behaviors
☐ Avoids crowds	☐ Health Problems	☐ Runs away from home
☐ Behavior at school	☐ Homicidal thoughts	☐ School Refusal
☐ Binge eating	☐ Hopelessness	☐ Self-Injury/cutting
☐ Boyfriend/girlfriend problems	☐ Hyperactive	☐ Sensitive
☐ Can't say no	☐ Immature for age	☐ Sets fires
☐ Conflict with Parents	☐ Impulsive	☐ Sexual Orientation Issues
☐ Conflict with Peers	☐ Lack of friends/ loneliness	☐ Sexually Acting Out
☐ Cries often	☐ Lack of motivation	☐ Sleep Problems
☐ Damages property	☐ Loss of interest in activities	☐ Social Anxiety/Shy
☐ Depression/sadness	☐ Low energy/always tired	☐ Stepfamily problems
☐ Difficulty Making Decisions	☐ Low Self Esteem	☐ Suicidal Thoughts
☐ Divorce – problems with	☐ Lying or stealing	☐ Suicide Attempts
☐ Doesn't follow rules	☐ Major life Change	☐ Tired all the time
☐ Doesn't like to leave home	☐ Manipulative	☐ Victim of Bullying
☐ Doesn't trust people	☐ Memory Problems	☐ Victim of Rape
☐ Domestic violence in home	☐ Mood Swings	☐ Weight Gain/Loss
☐ Experienced trauma	☐ Negative thoughts/outlook	☐ Withdrawn

NOTES:

Guardian Signature _____ ***Date*** _____