Child/Adolescent Intake

Name_____________________________________ Date ____________________

Address____

Date of Birth_____/_____/_____ Age _____

Mother/Guardian Name_________________________ Phone_________________

Father/Guardian Name_________________________ Phone_________________

Address (if different than client)____

Relationship Status______________________

Please list any other person(s) living in child's home_________________________

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____

Primary Care Physician Address & Phone

How did you hear about Huntingdon Valley Wellness? _______________________

Please describe your reason for seeking treatment at this time. Please include when the problem started.

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Please check all that apply.

Depression___	Anxiety___	Chronic Illness___	Chronic Pain___
ADHD___	Sexuality/Sexual Issues___	Family Conflict___	Grief/Loss___
Abuse___	Eating/Weight Problems___	Anger___	Phobias___
Obsessions___	Compulsions___	Trauma___	

Please list at least 3 of the child's strengths

____

____

Please list at least 3 of the family's strengths

____

____

Please list any Early Intervention Services.
____
____

Were any Developmental Milestones delayed (crawling, walking, growth/weight gain, etc.)
____
____

Please list methods of discipline and their effectiveness
____
____

What are your expectations for treatment.
____
____

School________________________________ Grade _______________
Do you enjoy school? Y N

Describe any academic problems you have experienced in the past or currently:
____
____
____
____

List any problems or conflicts you have had at school apart from academics:
____
____
____
____

Social
Do you make friends easily? Y N
How many close friends do you have? ______
How many acquaintances? ______
How would you describe these friendships:
____
____
____

Clubs/ organizations
____
____
____

Hobbies
____

Experience with mental health professionals
Have you received therapy in the past? Yes No
Whom have you seen?
____
____
____

Individual therapy _____ Group therapy _____
Quality of experience with therapist: (rate by circling a number) (Negative)1 2 3 4 5 (Positive)
Have you been in the care of a psychiatrist? Yes   No
Whom have you seen?
____
____
____

Quality of experience with psychiatrist: (rate by circling a number) (Negative)1 2 3 4 5 (Positive)
Do you experience or have a diagnosis of any of the following?
Depression____ Anxiety ____ ADHD ____ Bipolar Disorder____ Suicidal Ideation____ Other____

Medications used for psychiatric problems:
____
____
____

Other Health Information
This information is important for understanding your own personal health challenges.
Please check those that apply.

Ear Infections ___	Asthma ___	Head Injury ___	Seizures ___
Diabetes ___	Allergic Reactions ___	Measles ___	Mumps ___
Chicken Pox ___	Tonsillitis ___	Polio ___	Pneumonia ___
Bronchitis ___	Meningitis ___	Tuberculosis ___	Headaches ___]
Muscle Aches ___	History of Broken bones ___	Frequent Cold/Flu ___	Stomach Aches ___

Thyroid disease (circle one)   Hypothyroidism (low)   Hyperthyroidism (high)
Brain Disease ___   What kind? ________________________
Cancer ___   What part of the body is affected? ____

Sleep Problems
Please check all that apply.

Insomnia ___	Frequent waking ___	Less than 6 hours ___
Nightmares ___	Early morning awakening ___	More than 10 hours ___
Sleepwalking ___	Restless sleep/Tired ___	Wetting ___ Soiling ___

Surgeries (please list)
____
____
____
New