Adolescent Patient Intake Form

If you are a returning patient, please fill in only the information that has changed.

A. Identification.

Child's name:______________________ Date of birth:__________ Age:__________

Nicknames or aliases:______________________ Date of Child's first Office visit:__________

Home street address:______________________ Apt:__________

City:______________________ State:______ Zip:__________

Home/evening phone:______________________ E-mail:______________________

Calls or e-mail will be discreet, but please indicate anyrestrictions:______________________

Child's Gender:______________________ Child's Birth Gender:______________________

Child's Parent(s) or Legal Guardian(s):______________________

Biological or Adopted:______________________ If adopted, Child's age at adoption:__________

Child's ethnic background:______________________ Primary Language spoken at home:__________

If the child is not living with both natural parents (please answer the below questions):

Were parents married?__________ When?______________________

Were parents divorced?__________ When?______________________

Is either natural parent deceased?__________ When?______________________

Other Marriages?______________________

Briefly explain any special circumstances (foster-care, custody arrangements, visiting rights, etc.)

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How long has the child resided at the present address?______________________

Does the child share a bedroom with anyone?__________ If yes, with whom?______________________

If the child does not live with both natural parents, both adoptive parents, or only living parent, I require a photocopy of the legal document stating custody arrangements; consisting of the cover page, page specifying conservators and signature page, before the child can be seen.

B. Religious and racial/ethnic identification.

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑Jewish ❑Islamic ❑Buddhist ❑Hindu

Other (specify): ______________________

Involvement: ❑None ❑Some/irregular ❑Active

How important are spiritual concerns in your child's life? ______________________________

Which (if any) church, synagogue, temple, or meeting does your child attend? ______________________________

Ethnicity/national origin:______________________________Race(s):______________________________

C. Education

Child's School:______________________________#Years attended:__________Grade level:______________

Teacher:______________________________School Counselor:______________________________

D. Patient Information

Has your child had any prior counseling or are the currently in any type of counseling:______________________________

Name, Address, and Phone number of current therapist:______________________________

How successful did you find previous counseling?

____

____

Is the child currently seeing a medical psychiatrist?______________If yes, please provide their name, address, and phone #:

____

Is the child taking any medications?__________________If yes, what type of medication does the child take and why was it prescribed?

____

Does the medication help?____

When was their last physical exam?______________________Given by whom?______________________________

What were the results?

____

____

E. Patient medical care.

From whom or where does the child receive medical care? ______________________________

Phone:__________________________Address:____

Any chronic pain or serious health concerns? ______________________________

If the patient enters treatment with me for Mental health concerns, may I tell their medical doctor so that she or he can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

F. Presenting concerns.

What is the main concern about your child that brought you to see me? ______________________________

____

____

____

How long have these concerns existed?____

What kind of stressors is your child experiencing right now? ______________________________

____

WHAT IMPORTANT THINGS ABOUT YOUR CHILD, THEIR RELATIONSHIPS, OR RECENT EVENTS WOULD BE HELPFUL FOR YOUR THERAPIST TO KNOW? (I.E. HANDICAPS, DEATHS, DIVORCES, SCHOOL/JOB CHANGES, SUICIDE) ____________________

____

____

____

DOES THIS CHILD HAVE ANY ACADEMIC CONCERNS?__________IF YES, PLEASE ELABORATE:____________________

____

HAVE THEY EVER REPEATED A GRADE?__________WHICH GRADE & WHY?____________________

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

❑ THOUGHTS OF HARMING SELF

EXPLAIN: ____________________

❑ ATTEMPTS TO HARM SELF

EXPLAIN: ____________________

❑ PSYCHIATRIC HOSPITALIZATIONS

EXPLAIN: ____________________

❑ ATTEMPTED SUICIDE

EXPLAIN: ____________________

❑ SUICIDAL NOW

EXPLAIN: ____________________

G. PREGNANCY AND DELIVERY

LENGTH OF PREGNANCY:__________BIRTH WEIGHT______LBS______OZ PLEASE DESCRIBE ANY PREGNANCY COMPLICATIONS:________

____

DRUG/ALCOHOL USE DURING PREGNANCY?__________IF YES, PLEASE DESCRIBE:____________________

____

H. EARLY CHILDHOOD

CHILD WALKED

___LESS THAN 12 MONTHS
___12-24 MONTHS
___24-36 MONTHS
___OVER 36 MONTHS
___HAS NEVER WALKED

CHILD SPOKE WORDS

___LESS THAN 12 MONTHS
___12-24 MONTHS
___24-36 MONTHS
___OVER 36 MONTHS
___HAS NEVER SPOKEN WORDS

SPOKE SENTENCES

___LESS THAN 12 MONTHS
___12-24 MONTHS
___24-36 MONTHS
___OVER 36 MONTHS
___HAS NEVER SPOKEN SENTENCES

CHILD FIRST TRAINED FOR URINATION

___LESS THAN 12 MONTHS
___12-24 MONTHS
___2-3 YEARS
___3-5 YEARS
___NOT YET TRAINED

CHILD FIRST TRAINED FOR BOWELS

___LESS THAN 12 MONTHS
___12-24 MONTHS
___2-3 YEARS
___3-5 YEARS
___NOT YET TRAINED

SINCE INITIAL TOILET TRAINING

___FREQUENT WETTING DURING DAY
___FREQUENT WETTING AT NIGHT

SINCE INITIAL TOILET TRAINING

___FREQUENT SOILING DURING DAY
___FREQUENT SOILING AT NIGHT

I. Puberty

The onset of puberty (breast development, menstruation, pubic hair, facial hair)

___ Under 10 years
___ 10-12 years
___ 12-14 years
___14-16 years
___Over 16 years
___No development

J. Illness and Diseases *(please check any illness or disease which your child has or did have)*

____Eczema
____Diabetes
____Cancer
____Measles
____Mumps
____Chicken pox
____Diphtheria
____Scarlet fever
____Polio
____Cerebral palsy
____Lead poisoning
____Encephalitis
____Asthma
____Tuberculosis
____Heart disease
____Influenza
____Migraine headaches
____Undescended testicles
____High blood pressure
____Low blood pressure
____Sinusitis
____Appendicitis
____Heart surgery
____Tonsillectomy
____Convulsions
____Brain injury
____Fainting
____Dizziness
____Meningitis
____Broken bone(s)
____Others (write in)
____
____

K. Treatment. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

Has Child ever been hospitalized for mental or nervous problems? ❑ No ❑ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

Has child ever taken medications for psychiatric or emotional symptoms? ❑ No ❑ Yes If yes, please indicate:

From whom?	When?	Which medications?	For what?	With what results?

L. Relationships in child's family of origin and child's family history

Child's parents' relationship with each other: ____

____

Child's relationship with each parent and with any other adults present: ____

____

____

CHILD'S PARENTS' MEDICAL PROBLEMS, DRUG OR ALCOHOL USE, AND MENTAL OR EMOTIONALDIFFICULTIES: ______

______

______

______

CHILD'S RELATIONSHIP WITH SIBLING(S), IN THE PAST AND PRESENT: ______

______

______

______

CHECK ALL OF THE FOLLOWING FAMILY CONCERNS THAT APPLY CURRENTLY OR IN THE LAST 6 MONTHS:

__MARITAL DIFFICULTIES
__RECENT DEATH OF FRIEND
__FINANCIAL PROBLEMS
__BIRTH OF A SIBLING
__AGING GRANDPARENTS
__ALCOHOLISM
__PARENT IN THE HOME
__MOVE TO A NEW HOME
__TRAUMATIC EXPERIENCE
__MOVE TO A NEW SCHOOL
__SERIOUS ILLNESS OF THE CHILD
__SERIOUS ILLNESS OF A RELATIVE
__DRUG ADDICTION IN FAMILY
__OLDER SIBLING LEAVING HOME
__RECENT DEATH IN THE FAMILY

M. ABUSE HISTORY.

❑ MY CHILD WAS NOT ABUSED IN ANY WAY. ❑ MY CHILD WAS ABUSED.

IF YOUR CHILD WAS ABUSED, PLEASE INDICATE THE FOLLOWING. FOR KIND OF ABUSE, USE THESE LETTERS: P = PHYSICAL, SUCH AS BEATINGS.

S = SEXUAL, SUCH AS TOUCHING/MOLESTING, FONDLING, OR INTERCOURSE. N = NEGLECT, SUCH AS FAILURE TO FEED, SHELTER, OR PROTECT. E = EMOTIONAL, SUCH AS HUMILIATION, ETC.

AGE?	KIND OF ABUSE?	BY WHOM?	EFFECTS ON CHILD?	WHOM DID THEY TELL?	CONSEQUENCES OF TELLING?

N. SOCIAL & BEHAVIORAL

PLEASE CHECK THE ITEMS THE CHILD HAS DIFFICULTY WITH:

__AUDITORY
__BLANKING OUT
__BREATH HOLDING
__CAN'T FALL ASLEEP
__DAREDEVIL BEHAVIOR
__DIARRHEA
__EARLY WAKING
__EATING
__VISION
__FOCUS ON OBJECTS, NOT PEOPLE
__FORGETFUL
__GIVING UP
__HABITS
__HEAD BANGING
__CLUMSINESS
__CONSTIPATION
__HYPERACTIVITY
__IMPULSIVITY
__INTERRUPTED SLEEP
__MANNERISMS
__NAIL BITING
__NIGHT TERRORS
__NIGHTMARES
__VERBAL AGGRESSION
__OTHER LANGUAGE
__PHYSICAL AGGRESSION
__ROCKING BODY
__SHYNESS
__SIBLING CONFLICT
__SOCIAL ISOLATION
__COORDINATION
__DANGEROUS BEHAVIOR
__SLOWNESS TO LEARN
__SOILING
__SPEECH
__STUBBORNNESS, REGIDITY
__TANTRUMS
__THUMB SUCKING
__FEARS
__MOVE TO A NEW SCHOOL
__DRUG ADDICTION IN FAMILY
__OLDER SIBLING LEAVING HOME
__RECENT DEATH IN THE FAMILY
__OTHER

______

______

Describe briefly any special interest, hobbies, and recreational activities in which family members partake:

Child: ______________________________

Mother: ______________________________

Father: ______________________________

Siblings: ______________________________

Describe an important family value: ______________________________

____

____

Name of Adult completing this form: ______________________________

A. Emergency information.

If some kind of emergency arises and we cannot reach you, or we need to reach someone close to you, whom should we call?

Name: ______________ Phone: ______________ Relationship: ______________

Address: ______________________________

If you are not submitting claims to your insurance company, then to whom should your bills be directed:

❑ Self

❑ Other: ______________ ______________ ______________

(Name) (Address) (Phone)

Parent/Guardian Signature: ______________________________ Date: ______________

Parent/Guardian Signature: ______________________________ Date: ______________

Printed Names of Parents: ______________________________