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 atadoption:_____

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.)

_____

_____

_____

_____

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

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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
___24-36 MONTHS
___3-5 YEARS

___NOT YET TRAINED

CHILD FIRST TRAINED FOR BOWELS

_LESS THAN 12 MONTHS
_12-24 MONTHS
_24-36 MONTHS
_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: _____

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