Child & Adolescent Intake

Client Information

Name: _____ Date of Birth: _____ Age: _____

Social security number: _____

Child lives with: _____

Address: _____

Phone number: _____ Alt. Phone number: _____

Email address (REQUIRED): _____

Insured's name: _____ Insured's Date of Birth: _____

Insured's social security number: _____

School: _____ Grade: _____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Date of the last medical exam: _____

Psychiatrist: _____

Family Information

Mother's Name: _____ Age: _____ Occupation: _____

Employment status: _____ Employer's name and address: _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

_____

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History of alcohol/drug use? _____

History of arrest? _____

Primary Care Physician: _____

Psychiatrist: _____

Father's Name: _____ Age: _____ Occupation: _____

Employment status: _____ Employer's name and address: _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

_____

History of alcohol/drug use? _____

History of arrest? _____

Primary Care Physician: _____

Psychiatrist: _____

Step-parent/Guardian: _____ Age: _____ Occupation: _____

Employment status: _____ Employer's name and address: _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling :_____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

_____

History of alcohol/drug use? _____

History of arrest? _____

Primary Care Physician: _____

Psychiatrist: _____

Step-parent/Guardian: _____ Age: _____ Occupation: _____

Employment status: _____ Employer's name and address: _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

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Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

_____

History of alcohol/drug use? _____

History of arrest? _____

Primary Care Physician: _____

Psychiatrist: _____

Siblings

1. Sibling's Name: _____ Age: _____ Child lives with: _____

School: _____ Grade: _____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____

2. Sibling's Name: _____ Age: _____ Child lives with: _____

School: _____ Grade: _____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____

3. Sibling's Name: _____ Age: _____ Child lives with: _____

School: _____ Grade: _____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

_____

Significant medical problems: _____

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Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____

History of Problem

Please describe what concerns you have regarding your family: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Parent Information

Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, etc)?

_____

_____

Did the child's mother smoke tobacco or use any alcohol, drugs, or medications during the pregnancy?

_____

_____

Did the child's mother have any problems during the pregnancy or at delivery? _____

_____

_____

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Life Concern		History of Concern				Amount of Distress		
		Current	Past	Never		Often	Seldom	Never
Discipline problems		□	□	□		□	□	□
Aggressive behavior		□	□	□		□	□	□
Hyperactivity		□	□	□		□	□	□
Temper tantrums		□	□	□		□	□	□
Depression		□	□	□		□	□	□
Anxiety		□	□	□		□	□	□
Poor impulse control		□	□	□		□	□	□
Panic attacks		□	□	□		□	□	□
Phobias		□	□	□		□	□	□
Poor self esteem		□	□	□		□	□	□
Identity concerns		□	□	□		□	□	□
Witness to violence		□	□	□		□	□	□
Bedwetting/soiling		□	□	□		□	□	□
Appetite disturbance		□	□	□		□	□	□
Eating issues		□	□	□		□	□	□
Sleep disturbance		□	□	□		□	□	□
Learning problems		□	□	□		□	□	□
Lack of motivation		□	□	□		□	□	□
Conduct issues		□	□	□		□	□	□
Poor school performance		□	□	□		□	□	□
Problems with teachers		□	□	□		□	□	□
Problems with peers		□	□	□		□	□	□
Distractibility/attention problems		□	□	□		□	□	□
Alcohol and or substance abuse		□	□	□		□	□	□
Self-cutting		□	□	□		□	□	□
Suicide attempts/thoughts		□	□	□		□	□	□
Speech problems		□	□	□		□	□	□
Family communication problems		□	□	□		□	□	□
Death or major illness in family		□	□	□		□	□	□
Adjusting to divorce or separation		□	□	□		□	□	□
Parental stress		□	□	□		□	□	□
Single parenting problems		□	□	□		□	□	□
Step-parenting problems		□	□	□		□	□	□
Health issues		□	□	□		□	□	□
Family history of mental illness		□	□	□		□	□	□
Other:		□	□	□		□	□	□

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School

What school does your child attend? _____

Teacher's Name: _____ Grade: _____

What does the Teacher say about him/her? _____

_____

What other schools has your child attended? _____

Has your child ever repeated a grade? _____Which one? _____

Has your child ever received special education? _____

Has your child experienced any of the following problems at school? (circle any that apply)

Fighting	Lack of friends	Drugs/Alcohol	Detention
Suspension	Learning Disabilities	Poor Attendance	Poor Grades
Gang Influence	Incomplete Homework	Behavior Problems	

Medical

Has your child experienced any of the following medical problems? (circle any that apply)

A serious accident	Hospitalization	Surgery	Asthma	
Head injury	High Fever	Convulsions/Seizures		Eye/Ear Problems
Meningitis	Hearing Problems	Allergies	Loss of Consciousness	

Please list any current medical conditions or physical disabilities: _____

_____

_____

Please list any medications your child takes on a regular basis: _____

_____

_____

Social

What does your child enjoy? _____

What is he/she good at? _____

Who are his/her friends and for how long? _____

_____

What forms of discipline do you use? _____

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Behavioral

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of. _____

_____

_____

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of. _____

_____

_____

What does your child do that you like? What does he /she do that other people like? _____

_____

_____

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

_____

_____

_____

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

_____

_____

_____

Has he/she ever purposely hurt himself or another? If yes to either question, please describe the situation.

_____

_____

_____

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain: _____

_____

_____

Finally, what are some of the things that are currently stressful to your child and his/her family?

_____

_____

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Do you have any other concerns about your child or your family that have not been mentioned? _____

_____

_____

_____

Treatment Goals

From your preceding list of your child's behavior and your family concerns, what problems or behaviors do you believe need to change? _____

_____

_____

_____

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