

Child/Adolescent Intake Form

Name:			Date:
	PRESENTING PROBL	LEMS AND CONCERNS	<u> </u>
Describe the problem that b	rought you here today:		
Please check all your child's Distractibility Hyperactivity Impulsivity Boredom Poor memory/confusion Sadness/depression Hopelessness Thoughts of death Self-harm behaviors Crying spells Loneliness Low self worth Fatigue Recurring, disturbing me	 Withdrawal from people Anxiety/worry Panic attacks Fear away from home Social discomfort Phobias Obsessive thoughts Compulsive behavior Racing thoughts Wide mood swings Suspicion/paranoia Hearing voices 	at you consider problemati Visual hallucinations Defiance Aggression/fights Homicidal thoughts Frequent arguments Irritability/anger Peer/sibling conflict Stealing Destroys property Running away Swearing Curfew violations Lying Other:	☐ Manipulative behavior☐ No/few friends☐ Eating problems☐ Sleep problems
☐ Handling everyday tasks☐ Recreational activities☐ Yes ☐ No Has you		using Legal rule Legal rule statements, or attempte	ne
olease describe:	r child ever had thoughts, ma	·	·
☐ Yes ☐ No Ha	r child gambled in the past 6 as your child ever felt the nee as your child ever had to lie to	d to bet more and more mo	oney?
Therapist Notes:			
			Init:
			init.

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FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Lives with Child?	Age	Quality of Relationship	Family Mental Health Who? Problems
Mother		01			Hyperactivity
Father					Sexually Abused
Stepmother					Depression
Stepfather					Manic Depression
Siblings					Suicide
Olbilligs					Anxiety
					Panic Attacks
					Obsessive-Compulsive
Other relatives					Anger/Abusive
Other relatives					Schizophrenia
					Eating Disorder Alcohol Abuse
					Drug Abuse
☐ Parents divo	oorarily separated rced or permanently your child has expe	-		_	emarried: Number of times of trauma or loss:
Emotional above Sexual abuse Physical abuse Parent subst	ouse e se ance abuse	□ N □ V □ C □ P	eglect iolence rime vid arent ill	in the home	☐ Lived in a foster home☐ Multiple family moves☐ Homelessness☐ Loss of a loved one
☐ Yes ☐ No describe:	Were there any	medical pi	roblems	s during the preg	nancy or birth of your child? If yes, please
☐ Yes ☐ No with this child?					ation, street drugs, or alcohol while pregnarnd frequency:
Yes No toileting, etc.)?	Did your child ha If yes, please descr				early childhood (crawling, walking, talking,
Therapist Note	es:				
					Init:

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Name:

PREVIOUS MENTAL HEALTH TREATMENT

Yes No	Type of Treatment	When?	Provider/Program	R	leason for Treatn	nent
	Outpatient Counseling					
	Medication (mental health)					
	Psychiatric Hospitalization					
	Drug/Alcohol Treatment					
	Self-help/Support Groups					
	Con Holp/Capport Groups					
Therap	ist Notes:					
						Init:
		SCH	IOOL INFORMATI	ION		
Current	grade/placement:	\ <u></u>				
	ar's school grades: nool grades:			Good Good	∐ Fair ∏ Fair	☐ Poor ☐ Poor
	ar's school behavior: nool behavior:	=		Good Good	☐ Fair ☐ Fair	☐ Poor ☐ Poor
			_	2000		<u> </u>
	ır child had any of the followinç pension ☐Incomplet	g difficultie e homewo	ork 🔲 Learning p	oroblems	☐ Referrals or	detentions
	grades	r picked o		roblems	Attendance	problems
		ve an afte	r-school provider? I	fso who?		
_	-		•			
☐ Yes	·	·	l or skipped a grade		, ,	
	☐ No Has your child eve d and reason for services:	r received	Special Education s	ervices? If	yes, please desc	cribe services
	es your child's teacher(s) say	about him	ı/her?			
		about IIIII				
Inerap	ist Notes:					
						Init:

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SUBSTANCE USE HISTORY (for ages 12 and older or if applicable)

Substance Type	1		Current Use (las	at 6 months)				Past Us	20
Substance Type	Υ	N	· · · · · · · · · · · · · · · · · · ·	Amount	Y	N	Erogue		
Tobooo	T	IN	Frequency	Amount	ı	IN	Freque	ency	Amount
Tobacco									
Caffeine									
Alcohol									
Marijuana									
Cocaine/crack									
Ecstasy									
Heroin									
Inhalants									
Methamphetamines									
Pain Killers									
PCP/LSD									
Steroids									
Tranquilizers									
Tranquii 2010	l .	l							
please describe:	you	ır ch	ild ever had prob	olems with work,	relations	hips	health,		stances? If yes, etc. due to his/her
Therapist Notes:									
11101001									
									lnit:
									Init:
Date of last physical ex Has your child experien Allergies Chronic pain			of the following Asthma Surgery	medical conditio Headache Serious a	es	g his/	☐ Ston ☐ Head	nach ache d injury	
☐ Dizziness/fainting ☐ High fevers ☐ Miscarriage ☐ Other:			☐ Meningitis ☐ Diabetes ☐ Abortion	Seizures Hearing p Sleep disc			🗌 Ear i	on problem nfections ually transi	nitted disease
Please list any CURRE	NT I	neal	th concerns:						
Current prescription me	dica	tion	s: Non						
Medication			Dosage	Date	e First Pr	escri	bed	Pre	escribed By
Current over-the-counte	er m	edic	ations (including	vitamins, herba	l remedie	s, et	c.):		
Allergies and/or adversif yes, please list:					ne				
Therapist Notes:									
									Init:

Name:	

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

To which cultural or ethnic group does your child belong? If your child is experiencing any difficulties due to cultural or ethnic issues, p How important are spiritual matters to your child? Not at all Little Yes No Would you like spiritual/religious beliefs to be incorporal Please describe your child's strengths, skills, and talents? Describe any special areas of interest or hobbies (art, books, physical fitnes) Therapist Notes:	Somewhat
☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporal Please describe your child's strengths, skills, and talents?	red into your child's counseling?
Describe any special areas of interest or hobbies (art, books, physical fitnes	
	s, etc.):
Therapist Notes:	
	Init:
LEGAL INFORMATION	
If the parents are separated or divorced, what is the current child custody/vi	sitation arrangement?
Yes No Is your child currently the subject of a custody case	?
Yes No Has your child ever been a ward of the court with D	
Yes No Does your child have any legal offenses on record	•
Yes No Do you have an open DSS/DHS case? If so, please	write the name and
contact information for your caseworker below.	
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