

# CHILDREN/ADOLESCENT INTAKE FORM

Client’s name: Date: Gender: F M Date of Birth: Age: Grade in school: Form completed by:

# Primary reason(s) for seeking services:

 Anger management Anxiety Coping Depression

 Eating disorder Fear/phobias Family Conflict Noncompliance

 Sleeping problems Obsessive/Compulsive behaviors Alcohol/drugs

 Hyperactivity School Problems Social Problems Trauma

 Other concerns (specify):

# Family History

**Parents**

With whom does the child live at this time? Are parent’s divorced or separated? If Yes, who has legal custody?

# Client’s Mother

Name: Age: Occupation: FT PT Where employed: Work phone: Mother’s education: Is the child currently living with mother? Yes No

Is there anything notable, unusual or stressful about the child’s relationship with the mother?

 Yes No If Yes, please explain:

How is the child disciplined by the mother?

# Client’s Father

Name: Age: Occupation: FT PT Where employed: Work phone:

Father’s education:

Is the child currently living with father? Yes No

Is there anything notable, unusual or stressful about the child’s relationship with the father?

 Yes No If Yes, please explain:

How is the child disciplined by the father?

# Client’s Siblings and Others Who Live in the Household

Quality of relationship

Names of Siblings Age Gender Lives with the client

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|   |  F M |  home |  away |  poor |  average |  good |
|   |  F M |  home |  away |  poor |  average |  good |
|   |  F M |  home |  away |  poor |  average |  good |
|   |  F M |  home |  away |  poor |  average |  good |

Others living in the household: (cousin, foster child, etc.)

 F M poor average good

 F M poor average good

Comments:

Who is responsible for this child in the following areas?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| School: Health: |  Mother Mother |  Father Father |  Shared Shared |  Other (specify):  Other (specify):  |
| Problem behavior: |  Mother |  Father |  Shared |  Other (specify):  |

# Family Health/Mental Health History

Have any of the following existed among the child’s biological relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

|  |  |  |
| --- | --- | --- |
|  Depression |  Anxiety |  Autism/Other PDD |
|  ADHD |  Schizophrenia |  Bipolar Disorder |
|  Migraines |  Muscular Dystrophy |  Seizures |
|  Suicide |  Mental Retardation |  Other (specify):  |
|  Cancer |  Stomach Problems |  Other (specify):  |

Comments re: Family Health/Mental Health

# Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? Are you experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, describe:

# Spiritual/Religious

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group?

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No If Yes, describe:

# Childhood/Adolescent History

**Pregnancy/Birth**

Was the pregnancy with child planned? Yes No

Length of pregnancy: Baby’s birth weight:

Mother’s age at child’s birth: Father’s age at child’s birth:

Child number of total children.

While pregnant did the mother smoke or use drugs or alcohol? Yes No

If Yes, type/amount:

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) Yes No

If Yes, describe: Describe any physical or emotional complications with the delivery or after the birth:

**Infancy/Toddlerhood** Check all which apply:

 Breast fed Milk allergies Vomiting Diarrhea

 Bottle fed Rashes Colic constipation

 Not cuddly Cried often Rarely cried Overactive

 Resisted solid food Trouble sleeping Irritable when awakened Lethargic

**Developmental History** Please note the age at which the following behaviors took place: Toilet Trained: Spoke Words: Took 1st steps: Fed Self: Injuries or hospitalizations:

Issues that affected child’s development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

# Education

Current school: Grade: In special education? Yes No If Yes, describe: In gifted program? Yes No If Yes, describe: Has child ever been held back in school? Yes No If Yes, describe:

Which subjects does the child enjoy in school? Which subjects does the child dislike in school? What are the child’s grades in school at the present time?

Have there been any recent changes in the child’s grades? Yes No If Yes, describe:

Has the child been tested psychologically? Yes No If Yes, describe:

# Approach to School Work:

 Organized Industrious Responsible Interested

 Self-directed No initiative Refuses Does only what is expected

 Sloppy Disorganized Cooperative Doesn’t complete work

 Other (describe):

# Performance in School (Parent’s Opinion):

 Satisfactory Underachiever Overachiever

 Other (describe):

# Child’s Peer Relationships:

 Spontaneous Follower Leader Difficulty making friends

 Makes friends easily Long-time friends Shares easily

 Other (describe):

# Vocational:

Vocational Interests: Plan (i.e. college, trade school, internship):

# Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity How often now? How often in the past?

What are the family’s favorite activities?

What does the child/adolescent do with unstructured time?

# Health History

List any current health concerns:

List any recent health or physical changes:

Current prescribed meds Dose Dates Purpose Side effects

Current non-prescription meds Dose Dates Purpose Side effects

# Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? Yes No

If Yes, describe:

# Counseling/Prior Treatment History

Information about child/adolescent (past and present):

Reaction or

Yes No When Where overall experience Counseling

Psychotropic Medication Suicidal thoughts/attempts Drug/alcohol treatment Psych Hospitalizations

Comments:

# Behavioral/Emotional

Please check any of the following that are typical for your child:

|  |  |  |
| --- | --- | --- |
|  Affectionate |  Frustrated easily |  Sad |
|  Aggressive |  Gambling |  Selfish |
|  Alcohol problems |  Generous |  Separation anxiety |
|  Angry |  Hallucinations |  Sets fires |
|  Anxiety |  Head banging |  Sexual addiction |
|  Attachment to dolls |  Heart problems |  Sexual acting out |
|  Avoids adults |  Hopelessness |  Shares |
|  Bedwetting |  Hurts animals |  Sick often |
|  Blinking, jerking |  Imaginary friends |  Short attention span |
|  Bizarre behavior |  Impulsive |  Shy, timid |
|  Bullies, threatens |  Irritable |  Sleeping problems |
|  Careless, reckless |  Lazy |  Slow moving |
|  Chest pains |  Learning problems |  Soiling |
|  Clumsy |  Lies frequently |  Speech problems |

|  |  |  |
| --- | --- | --- |
|  Confident |  Listens to reason |  Steals |
|  Cooperative |  Loner |  Stomach aches |
|  Cyber addiction |  Low self-esteem |  Suicidal threats |
|  Defiant |  Messy |  Suicidal attempts |
|  Depression |  Moody |  Talks back |
|  Destructive |  Nightmares |  Teeth grinding |
|  Difficulty speaking |  Obedient |  Thumb sucking |
|  Dizziness |  Often sick |  Tics or twitching |
|  Drugs dependence |  Oppositional |  Unsafe behaviors |
|  Eating disorder |  Over active |  Unusual thinking |
|  Enthusiastic |  Overweight |  Weight loss |
|  Excessive masturbation |  Panic attacks |  Withdrawn |
|  Expects failure |  Phobias |  Worries excessively |
|  Fatigue |  Poor appetite |  Other: |
|  Fearful |  Psychiatric problems |   |
|  Frequent injuries |  Quarrels |   |

Please describe any of the above (or other) concerns:

Have there been any other significant changes or events in your child’s life? (family, moving, fire, deaths, etc.) Yes No If Yes, describe:

Any additional information that would assist us in understanding current concerns or problems?

What are your goals for the child’s therapy?

What family involvement would you like to see in the therapy?

Do you believe the child is suicidal at this time? Yes No

If Yes, explain:

Reviewed by:

Therapist’s signature/credentials:

Date: