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CHILDREN/ADOLESCENTS – Intake form

Client's Name: _____ Today's Date: _____

Date of Birth: _____ Gender: M____ F___ SSN: _____

Grade in School: _____

Form Completed by (If someone other than client): _____

Address: _____

Phone (Cell):_____ Phone (Work):_____

May I leave a message? Yes_____ No_____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

What is your preferred method of contact?

Phone: _____ Text*: _____ Email*: _____

*Please note: If you choose to contact your therapist through text message or email, confidentiality cannot be guaranteed. Please limit communication in these forms to scheduling, rescheduling or cancellations of sessions, and do not include personal information. Please do not communicate emergent information through text or email. If you would like the convenience of communicating about appointment times through text or email please **initial here: _____**

Reason(s) for seeking counseling services: (Circle all that apply)

Addictive Behaviors	Coping	Hyperactivity
Alcohol/Drugs	Depression	Mental Confusion
Anger Management	Fear/Phobias	Sleeping Problems
Anxiety	Grief	Sexual Concerns

Other Mental Health Concerns (Specify):_____

Parents/Guardians

With whom does the child live at this time? _____

Are parents divorced or separated? ___ Yes ___ No If yes, whom has legal custody? _____

Does either parent's rights supersede the others? ___ Yes ___ No

Were the child's parents ever married? ___ Yes ___ No

Is there any significant information about the parent's relationship or treatment toward the child which might be beneficial in counseling? _____

_____

Client's Mother

Name: _____ Age: _____ Occupation: _____

Place of Employment: _____ Work Phone: _____

Mother's education: _____

Is the child currently living with mother? ___ Yes ___ No

____Biological parent____Stepparent ____Adoptive parent ____Foster home ____Other

Is there anything notable, unusual or stressful about the child's relationship with the mother? If so, please explain: _____

_____

How is the child disciplined by the mother? _____

_____

For what reasons is the child disciplined by the mother? _____

_____

Client's Father

Name: _____ Age: _____ Occupation: _____

Place of Employment: _____ Work Phone: _____

Father's education: _____

Is the child currently living with father? ___ Yes ___ No

____Biological parent____Stepparent ____Adoptive parent ____Foster home ____Other

How is the child disciplined by the father? _____

_____

For what reasons is the child disciplined by the father? _____

_____

Family Information (Living in your Home):

Name	Relationship	Gender	Age
_____	_____	_____F _____M	_____
_____	_____	_____F _____M	_____
_____	_____	_____F _____M	_____
_____	_____	_____F _____M	_____
_____	_____	_____F _____M	_____
_____	_____	_____F _____M	_____
_____	_____	_____F _____M	_____

Pregnancy/Birth

Was the pregnancy with child planned? ___ Yes ___ No Length of pregnancy? _____

Mother's age at child's birth? _____ Father's age at child's birth? _____

Child is number: _____ of _____ total children.

While pregnant did the mother smoke? ___ Yes ___ No If yes, what amount? _____

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

If yes, what type / amount? _____

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

If yes, describe: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Spiritual/Religious

How important to you are spiritual matters? ____Not ____Little ____ Moderate ____Much

Are you affiliated with a spiritual or religious group? ___ Yes ___ No

If yes, describe: _____

Were you raised within a spiritual or religious group? ___ Yes ___ No

If yes, describe: _____

Would you like your religious/spiritual beliefs incorporated into this counseling? ___ Yes ___ No

Culture/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: _____

Other cultural/ethnic information: _____

Development

Infancy/Toddlerhood: Please **Circle** all that apply

Breast-fed	Lethargic
Bottle-fed	Milk allergies
Colic	Not cuddly
Constipation	Overactive
Cried often	Rarely cried
Diarrhea	Rashes
Irritable when awakened	Resisted solid food
Trouble sleeping	Vomiting

Developmental History: Please note the approximate age at which the following behaviors took place:

Sat Alone: _____	Spoke Sentences: _____
Dressed Self: _____	Tied Shoelaces: _____
Took First Steps: _____	Rode Two-Wheeled Bike: _____
Spoke First Words: _____	Toilet Trained: _____
Frist Weaned: _____	Dry During Day: _____
Fed Self: _____	Dry During Night: _____

Compared with others in the family, child's development was: _____ Slow. _____ Average. _____Fast.

Age for following occurrences: (fill in where applicable)

Began puberty: _____ Menstruation:_____

Voice change: _____ Breast development: _____

Injuries or hospitalizations: _____

Are there special, unusual, or traumatic circumstance that affected your development?

___ Yes ___ No

Has there been history of child abuse? ___ Yes ___ No

If yes, which type(s)? _____Sexual _____Physical _____Verbal

If yes, the abuse was as a: _____Victim _____Perpetrator

Other childhood issues: _____Neglect _____Inadequate nutrition

Other (please specify):_____

Other comments regarding child development:

_____

_____

Social Relationships

How do you generally get along with other people? (**Circle** all that apply)

Affectionate	Fight/argue often	Leader	Submissive
Aggressive	Follower	Outgoing	
Avoidant	Friendly	Shy/Withdrawn	

Other (please specify):_____

Sexual Orientation: _____ Comments: _____

Sexual dysfunctions? ___ Yes ___ No

If yes, describe: _____

Any current history of being a sexual perpetrator? ___ Yes ___ No

If yes, describe: _____

Education

Current school: _____

Type of school: ___Public ___Private ___Home schooled ___Other (specify):_____

Is the child in special education classes? ___Yes ___No

If yes, describe: _____

Is the child in gifted classes? ___Yes ___No

If yes, describe: _____

Has the 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 grades does the child usually receive in school? _____

Have there been recent changes in the child's grades? ___Yes ___No

If yes, describe: _____

Has the child been tested psychologically? ___Yes ___No

If yes, describe: _____

Check the descriptions that specifically relate to your child.

Feelings about schoolwork:

____Anxious ____Passive ____Enthusiastic ____Fearful

____Eager ____No expression ____Bored ____Rebellious

____Other (describe):

_____

Approach to schoolwork:

____Organized ____Industrious ____Responsible ____Interested

____Self-directed ____No initiative ____Refuses ____Does only what is expected

____Sloppy ____Disorganized ____Cooperative ____Doesn't complete assignments

____Other (describe):_____

Performance in school (Parents' Opinion):

____Satisfactory ____Does not achieve goals ____Overachieves goals

____Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ___Mother ___Father ___Shared ___Other (specify):_____

Health: ___Mother ___Father ___Shared ___Other (specify):_____

Behavioral issues: ___Mother ___Father ___ Shared ___ Other (specify):_____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ___Poor ___Average ___Good ___Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? ____Lower ____Same ____Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

Medical/Physical Health

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above:

_____

_____

Most recent examinations	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctors visit	_____	_____	_____
Last vision exam	_____	_____	_____
Last hearing exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

Medications

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Allergic to any medications or drugs? ___ Yes ___ No

If yes, describe: _____

Nutrition

Meal	How often/week:	Typical foods eaten:	Typical amount eaten:
Breakfast	_____/week	_____	__No __Low __Med __High
Lunch	_____/week	_____	__No __Low __Med __High
Dinner	_____/week	_____	__No __Low __Med __High
Snacks	_____/week	_____	__No __Low __Med __High

Comments: _____

Chemical Use History

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

If yes, please describe and compete the information: _____

_____

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	____	____	____	____
Barbiturates	_____	_____	_____	_____	____	____	____	____
Valium/Librium	_____	_____	_____	_____	____	____	____	____
Cocaine/Crack	_____	_____	_____	_____	____	____	____	____

Heroin/Opiates	_____	_____	_____	_____	____	____	____	____
Marijuana	_____	_____	_____	_____	____	____	____	____
PCP/LSD/Mescaline	_____	_____	_____	_____	____	____	____	____
Inhalants	_____	_____	_____	_____	____	____	____	____
Caffeine	_____	_____	_____	_____	____	____	____	____
Nicotine	_____	_____	_____	_____	____	____	____	____
Over the counter	_____	_____	_____	_____	____	____	____	____
Prescription drugs	_____	_____	_____	_____	____	____	____	____
Other drugs	_____	_____	_____	_____	____	____	____	____

Substance of preference

1. _____ 3. _____

2. _____ 4. _____

Substance Abuse Questions to be answered by Child/Adolescent

Describe when and where you typically use substances:

_____

_____

Describe any changes in your use patterns:

_____

_____

Describe how your/their use has affected family or friends (include their perceptions of our use)

_____

_____

Reason(s) for use:

____Addicted ____Build confidence ____ Escape ____ Self-medication

____Socialization ____ Taste

____ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol? ___ Yes ___ No

If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___ Yes ___ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

_____

Does your body temperature change when you drink? ___ Yes ___ No

Have drugs or alcohol created a problem for your job or school? ___ Yes ___ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Child/Adolescent's Reaction to overall experience
Counseling/ Psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Information about **family/significant** others (past and present):

	Yes	No	When	Where	Child/Adolescent's Reaction to overall experience
Counseling/ Psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Behavioral/Emotional

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

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Short attention span
___ Shy, timid
__ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Other:
_____
_____

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

_____

How are your child's problematic behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Has the child/adolescent experienced death? (friends, family, pets, other) _____ Yes _____ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: __ _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

_____ Yes _____ No If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

What are your goals for the child's/adolescent's therapy?

_____

_____

What family involvement would you like to see in therapy?

_____

_____

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

If Yes, explain: _____

_____

What is your hope for coming to counseling?:

_____

_____

_____

_____

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date