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Child/Adolescent Client Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Name:

____

(Last) (First) (Middle Initial)

Birth Date: ______/______/______Age: ________Gender: □ Male □ Female

Primary Address:

____

(Street and Number)

____

(City) (State) (Zip)

Parent/Guardian Phone: (   ) _____________

May I leave a message? □ Yes □ No May I text this number? □ Yes □ No

E-mail: ____May I email you? □ Yes □ No

Who is the consenting parent or guardian?

____ Relation:_________________

*****The current divorce decree, custody paperwork, or adoption paperwork must be on file before sessions begin. As a courtesy to the other guardian, they will be notified of therapy services. It is the policy of this office to have transparency with both parties. If an email is sent to one guardian, the other guardian will be copied on the email. If a parent consult is requested, the other party will be invited to attend. I will not engage in any parental alienation. *****

Referred by:

____

Child's Support System

Please list important family members, friends, and other important people in your child's life.

Current Concerns:

□ Sadness, depression, or withdrawn
□ Change in appetite
□ Hurting animals
□ Change in sleep patters
□ Hyperactivity
□ self-harm (cutting, burning, head banging)
□ fighting
□ running away
□ unfounded fears
□ Anxiety, nervousness, or worrisome
□ Preoccupation with things
□ Hurting Others
□ Nightmares/night terrors
□ bed wetting/ incontinence
□ thoughts of hurting or killing self
□ preoccupation with death
□ bullying
□ anger

Is your child currently receiving psychiatric services? □ Yes □ No

If so, please write the psychiatrist's name: ___________________________________

Is your child currently receiving professional counseling or psychotherapy elsewhere?
□ Yes □ No

If so, where? ____

Has your child had previous psychotherapy? □Yes □No

Please list previous therapy providers below:

Is your child currently taking prescribed psychiatric medication (antidepressants, ADD/ ADHD, or others)? □Yes □No

If Yes, please list:

____

If no, has your child been previously prescribed psychiatric medication? □Yes □No

If Yes, please list: ____

Medical/Developmental

Was your pregnancy planned? □ Yes □ No
Any complications? □ Yes □ No
If yes, please explain:

____

Any drugs, alcohol, or injuries to mother and/or baby before birth? □ Yes □ No

If yes, please explain:____

____

Any complications during the delivery? □ Yes □ No
Was your child born prematurely? □ Yes □ No

Has your child met all of his/her developmental milestones? □ Yes □ No

If no, please explain:

Has your child been hospitalized for anything? □ Yes □ No

If yes, please explain and list when:

Sleep
Does your child exhibit any snoring? □ Yes □ No
Does your child have nightmares or night terrors? □ Yes □ No
Please tell me about your child's sleep routine:

____

____

School
School name: ____

School Counselor Name: ___________________________ Grade: ____________

Teacher's Name:__________________________________

What grades does your child receive on his/her report card?

Please tell me about his/her friends. Are they the same age? Different ages?

What is your child's favorite subject? Which subject does your child do well in?

If applicable, does your child have had any ARDs, 504, or an IEP? If so, for what?

Do they participate in any extra curricular activities?

Family

Please tell me who lives in the home.

What is your child's relationship like with his/her family members?

Any significant changes to your child's family life? (ex: divorce, moving, or a death)

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Depression: □ Yes □ No ____
Bipolar Disorder: □ Yes □ No ____
Anxiety Disorders: □ Yes □ No ____
Panic Attacks: □ Yes □ No ____
Schizophrenia: □ Yes □ No ____
Alcohol/Substance Abuse: □ Yes □ No_____________________________________
Eating Disorders: □ Yes □ No ____
Learning Disabilities: □ Yes □ No _______________________________________
Trauma History: □ Yes □ No ____
Suicide Attempts: □ Yes □ No ____

Occupational Information
Is your child currently employed? □ Yes □ No

If yes, who is their current employer/position?

____

Religion/Spirituality
Does your child consider him/herself to be religious? □ Yes □No

If yes, what is their faith?

If no, do you consider yourself to be spiritual? □ Yes □ No

Other Information
Do you talk with your child about sex and relationships? □ Yes □ No
If this topic comes up with your pre-teen/teenager, what do you feel comfortable with me talking about with your child?

What do you consider to be your child's strengths?

What are coping strategies your child utilizes?

What are your goals for your child’s therapy?