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CHILD/ADOLESCENT INTAKE FORM

GENERAL INFORMATION

Child's Name:____ Today's Date:_____________

Child's age:_____________ Date of Birth (DOB):__________________________

Address:____

____

Parent's Name: _________________________ Parent's Name: ____________________________________

Home phone:____ May I leave a message? Yes No

Cell phone:____ May I leave a message? Yes No

Work phone:____ May I leave a message? Yes No

Email: ____ May I email you? Yes No

(For appointment scheduling purposes only, as email not considered a confidential medium of communication).

Who referred your child to this practice?

____

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems):

____

____

____

What are your hopes regarding your child's therapy?_______________________________________

____

____

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems? ___________________________________

____

____

Has your child ever been treated for any of the following? If so please circle and describe:
Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions:

____

____

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

____

____

____

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

____

____

Please list your child's current prescription medications with dosage (psychiatric and general health):

____

____

____

Please list any previous psychiatric medications (with dosage and dates): ______________________

____

Do you suspect or know your child drinks alcohol or uses recreational drugs? If so, what kind & how often? _

____

____

Do you or anyone close to your child consider his/her use to be a problem? Yes No

Who is your child's primary care physician? ____

Who is your child's psychiatrist (if applicable)? ______________________________________

When was your child's last complete physical exam (mo/year)? ___________________________

How many times a week does your child exercise? _________What type & how many minutes? _____

____

What types of food does he/she often eat? ____

____

YOUR CHILD'S FAMILY

	BIOLOGICAL MOTHER	**BIOLOGICAL FATHER**
Current age, or if deceased, date, age, & cause of death		
Country of Origin		
Occupation		
Religious/Spiritual Affiliation (if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? ________________________

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? ____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:__

____

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	**Biological, Adopted or Step**	**Current Age**	**School grade?**	**Male/ Female**	**Lives with you? (Yes/No)**	**Any medical, social or academic problems (please list for each)?**

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

YOUR CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth

Where there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe:

____

Medications used during pregnancy? Please list: ______________________________

Smoking? Yes No How much? ______________________________
Alcohol intake? Yes No How much? ______________________________
Drug intake? Yes No How much? ______________________________
Length of pregnancy?_____Weeks Age of mother at birth: _______ Birth weight: ________

Were there any complications during delivery? If so, please describe: ______________________

____

Length of stay in the hospital? Mother: __________(days) Child: __________(days)

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each):

Turn over _____________ Crawl _______ Stand Alone_______ Walk Alone _________

First Words_____________ First Phrases_________

Toilet trained? Yes No If yes, days?_____________Nights? _________

Has your child wet or soiled himself after being trained? Yes No If yes, until what age?_________

Enjoyed cuddling? Yes No Fussy, Irritable? Yes No More active than other babies? Yes No

If your child has siblings, was development different in any way? Explain:____________________

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _______ Has he/she ever repeated a grade? Yes No If so, which? _________

School name: ____Public or Private (circle one)?

Street Address: ____

School District/County? ________________________ Phone: (______) __________________________

What preschool experience did your child have? ____

Where any problems detected in your child's kindergarten screening? Yes No If so, please explain:

____

Is your child in a regular classroom? Yes No Does your child have an IEP ? Yes No

Has your child ever received tutoring? Yes No If so, please explain: ___________________________

What are your child's typical grades? ____

What are your child's strongest and weakest points academically? _____________________________

____

Are you satisfied with your child's educational program? Yes No Please explain: __________________

____

Home/Family Life

What are the things that you enjoy most about your child? ___________________________________

____

What are some activities you engage in as a family? ____

What are your discipline techniques? ____

____

What are your strengths personally and as a parent? ____

What are some of your areas of needed growth? ____

What are your child's strengths (things he/she is good at)? ___________________________________

What are your child's areas of needed growth? ____

Social and Community Engagement

What are your child's favorite activities or hobbies? ______________________________

In what extracurricular/community activities is he/she involved? ______________________________

How does your child get along with other children? ______________________________

Who are some of your child's closest friends (first name) ______________________________

____

Your Child's Symptoms or Problems

How much are each of the following areas currently a problem for your child?

	Not at all 1	A little 2	Somewhat 3	Considerably 4	Terribly 5
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? Yes No
(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)?

If yes, please describe:______________________________

____

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: ____

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