

# Child and Adolescent Intake Form

Information provided on this form will be kept in the strictest of confidence.

Completed by whom \_\_\_\_\_

Date \_\_\_\_\_ Referral Source \_\_\_\_\_

## Contact Information

Child/Adolescent Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Name of Parent/Custodian(s) \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_

Street City/State Zip Code \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail \_\_\_\_\_

## Developmental History

Was this a planned pregnancy? \_\_\_\_\_

Did mother use drugs/alcohol during pregnancy? \_\_\_\_\_ if yes \_\_\_\_\_

Any problem during pregnancy? \_\_\_\_\_

Was the baby premature? \_\_\_\_\_ how much \_\_\_\_\_

Baby's birth weight \_\_\_\_\_

Were there any developmental problems during pregnancy, at birth, or other. Explain below:

\_\_\_\_\_  
\_\_\_\_\_

At what age did your child do the following? (months)

Sit up \_\_\_\_\_ mos.

Crawl \_\_\_\_\_ mos.

Walk \_\_\_\_\_ mos.

Say single words \_\_\_\_\_ mos.

Walk \_\_\_\_\_ mos.

Become toilet trained \_\_\_\_\_ mos.

## Some Information about Your Family

Age of father at child's birth \_\_\_\_\_

Age of mother at child's birth \_\_\_\_\_

Employment of father \_\_\_\_\_

Employment of mother \_\_\_\_\_

Father's education level \_\_\_\_\_

Mother's education level \_\_\_\_\_

Who currently lives in your household? \_\_\_\_\_

Name/Age

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

## Medical Information

Child's Doctor \_\_\_\_\_

Medications currently taking \_\_\_\_\_

Any side effects from medications \_\_\_\_\_

Have you been to counseling before? If so, please explain. \_\_\_\_\_

\_\_\_\_\_

Past and current medical/mental health diagnoses \_\_\_\_\_

Hospitalization history \_\_\_\_\_

Child/adolescent's biological mother's health history \_\_\_\_\_

\_\_\_\_\_

Child/adolescent's biological father's health history \_\_\_\_\_

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Sibling health history \_\_\_\_\_

Vision/Hearing \_\_\_\_\_

## **Education**

School attending \_\_\_\_\_ Current grade \_\_\_\_\_

Teacher's name \_\_\_\_\_

Past grades \_\_\_\_\_ Current grades \_\_\_\_\_

Prolong absentees \_\_\_\_\_

Any history of learning disabilities \_\_\_\_\_

Expelled from school? Yes \_\_\_ No \_\_\_

Relationship with friends at school \_\_\_\_\_

## **Problems/Risk Factors** (explain if you are experiencing any of the following)

Nutrition eating patterns \_\_\_\_\_

Pain in body \_\_\_\_\_

Mood \_\_\_\_\_

Grief/bereavement issues \_\_\_\_\_

Anxiety \_\_\_\_\_

Traumatic stress \_\_\_\_\_

Anger/Aggression \_\_\_\_\_

Bullying \_\_\_\_\_

Opposition behaviors \_\_\_\_\_

Impulsivity \_\_\_\_\_

Disturbed Reality \_\_\_\_\_

Substance use \_\_\_\_\_

Sleep problems \_\_\_\_\_

Psychosocial stressors \_\_\_\_\_

Withdraw behaviors \_\_\_\_\_

Bladder/bowel problems \_\_\_\_\_

Difficulties with attention or concentration \_\_\_\_\_

Attempted to kill self or injure self \_\_\_\_\_

Run away from home \_\_\_\_\_

Sexual behavior \_\_\_\_\_

Tobacco, alcohol \_\_\_\_\_

### **Some Information about You**

What brings you to counseling now? \_\_\_\_\_  
\_\_\_\_\_

What is the intensity/severity of the behavior? \_\_\_\_\_

Can you identify typical antecedents to the behavior, or does it seem to happen for no reason?

\_\_\_\_\_

What has been done to try and modify the behavior? \_\_\_\_\_

What effect does the problem have on the child and those around him/her? \_\_\_\_\_

\_\_\_\_\_

Extracurricular activities \_\_\_\_\_

\_\_\_\_\_

Who are the people in your life that mean the most to you? \_\_\_\_\_

\_\_\_\_\_

If you have a problem, who are you most likely to share it with? \_\_\_\_\_

\_\_\_\_\_

With whom do you enjoy spending time? \_\_\_\_\_

\_\_\_\_\_

Are you satisfied with your friendships? \_\_\_\_\_ If not, what do you wish were different? \_\_\_\_\_

\_\_\_\_\_

What are your interests/hobbies? \_\_\_\_\_

What are your plans for the future? \_\_\_\_\_

\_\_\_\_\_

What is the accomplishment of which you are most proud? \_\_\_\_\_

If we asked your friends to describe you with three words, what would they be? \_\_\_\_\_

\_\_\_\_\_

If we asked your parents to describe you with three words, what would they be? \_\_\_\_\_

\_\_\_\_\_

If you could change one thing about yourself, what would it be? \_\_\_\_\_

\_\_\_\_\_

**Describe your relationship with your parents:**

Past/Present

Mother \_\_\_\_\_

Father \_\_\_\_\_

Step-Mother \_\_\_\_\_

Step-Father \_\_\_\_\_

Do you like being with your family? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain \_\_\_\_\_

\_\_\_\_\_

Have you or someone in your family had a history of drug or alcohol abuse? If so, please describe. \_\_\_\_\_

\_\_\_\_\_

Is there a history of sexual abuse in your family? If so, please describe \_\_\_\_\_

\_\_\_\_\_

Is there history of physical or emotional abuse in your family? If so, please describe \_\_\_\_\_

\_\_\_\_\_

What else would you like the counselor to know about you or your present problem? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your goals for therapy?

\_\_\_\_\_

Print Name \_\_\_\_\_

## Self Assessment

Circle all that currently describes you:

Introvert	extrovert	quiet	calm	sensitive
compassionate	submissive	domineering	argumentative	controlling
moody	mean	hardworker	patient	easily agitated
impatient	fearful	impulsive	nervous	unforegiveness
follower	leader	anxious	revengeful	easily hurt
easily give up	talkative	ambitious	past hurts	aggressive
angry	insecure	low self esteem	analytical	wounded from childhood
bossy	physically violent	selfish	open	tolerant
high self esteem	over achiever	intellectual	kind	spiritual
feel inferior	I want out	high sex drive	low sex drive	I'm ugly
always prepared	full of ideas	like order	little to say	soft heart
hard heart	I insult people	detailed	imaginative	quick to understand
start conversation	interested in people	change mood	I'm evil	comfortable with people

Others \_\_\_\_\_