Child and Teen Intake Form

Name_____ Date of 1st Appointment_____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

School_____ Grade_____

Key Teacher/School counselor_____

MEDICAL HISTORY

Name of Primary Care Physician:

_____

Physician's Address:_____Physician's Phone:_____ Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO Please sign here for either answer:

_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken: 1)_____ Dosage/Freq _____
Start Date_____Purpose_____

2)_____ Dosage/Freq _____

Start Date_____Purpose_____

3)_____ Dosage/Freq _____

Start Date_____Purpose_____

4)_____ Dosage/Freq _____

Start Date_____Purpose_____ Prescribed by:

_____
_____

Has your child ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO Hospital Mo/Yr Reason

_____
_____
_____
_____
_____

Describe any important medical history, chronic ailments, or other health problems your child experiences:_____
_____
_____
_____
_____
_____

Does your child have a learning or physical disability? (Circle One) YES NO MAYBE. Describe:

_____
_____
_____
_____

Does your child have a mental health diagnosis? (Circle One) YES NO MAYBE. Describe:

_____
_____
_____
_____

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments:

_____
_____
_____
_____
_____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

_____
_____
_____
_____
_____

4/2010

DEVELOPMENTAL and FAMILY HISTORY

In the first two years of life, did your child experience:

___Separation from mother, ___Out of Home care, ___Disruption in bonding, ___Depression of mother, ___Abuse, ___Neglect, ___Chronic pain, ___Chronic Illness, ___Parental Stress

Reached developmental milestones: ___On Time, ___Early, ___Late

How many times has the child moved homes? _____

Biological Dad:_____ DOB:_____

Biological Mom:_____ DOB: _____

Married: __/__/__; Separated: __/__/__; Divorced: __/__/__

Siblings (1st to last)

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Custodial Adults (if not biological parents):

Dad: _____ DOB:_____

Mom: _____ DOB:_____

Date became caretaker: _____ People in household, if different from above:
_____
_____

_____

Does father work outside the home? ___ Yes ___ No;

Occupation: _____ Hours: _____ Father's highest level of education? _____ Does mother work outside the home? ___ Yes ___ No;
Occupation: _____ Hours: _____ Mother's highest level of education? _____

If separated or divorced, visitation schedule:
_____

Does either parent have legal issues? If YES, Describe
_____

Does your family have any specific spiritual or religious beliefs? If YES, Describe

_____
_____
_____
_____

List any mental illness or addiction in immediate or extended family (For example: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, eating disorders, ADHD, Schizophrenia)

_____
_____
_____
_____
_____
_____

Have your children witnessed domestic violence? ___Yes ___No. If Yes, describe:

_____
_____
_____
_____

How is your child disciplined? Please list each method and frequency of use:

_____
_____
_____
_____
_____

ACADEMIC AND SOCIAL HISTORY

ACADEMIC PERFORMANCE

Highest grade on last report card? _____

Lowest grade on last report card? _____

Favorite subjects in school?

_____
_____
_____

Least favorite subjects?

_____
_____
_____

Has your child had special testing in school? (If YES, please describe below) Psychological ____YES ____NO Learning ____YES ____NO Vocational ____YES ____NO

_____
_____
_____
_____

What would your child like to do about school at this point? ____Quit school ____Graduate from High School ____Go to College

In school, how many friends does your child have? ____ a lot ____a few ____none

Does child have friends in the neighborhood or close cousins they play regularly with?

____YES ____NO Describe:

_____

_____

_____

How does your child handle anger with peers and family?

_____

_____

_____

_____

What are your child interests, hobbies and regular activities?

_____

_____

_____

_____

_____

How much time does your child play on the computer, watch TV or play video games?

_____

_____

_____

_____

_____

Has your child ever had difficulty with the Police?

_____

_____

_____

_____

Has your child ever appeared in Juvenile Court?

_____

_____

_____

_____

Has your child ever been on Probation? Dates _____
Reason_____
_____
_____
_____
Probation Officer _____

Has your child ever been employed?

Dates _____ Employer _____
Job_____
_____
_____

TRAUMA HISTORY

Has your child been verbally abused? ___Yes ___No ___Suspected Describe:
_____
_____
_____
_____

Has your child been physically abused? ___Yes ___No ___Suspected Describe:
_____
_____
_____
_____

Has your child been sexually abused? ___Yes ___No ___Suspected Describe:
_____

_____
_____

Other stressors or traumas?
_____
_____
_____
_____

CONCERNS, STRENGTHS AND GOALS

Circle the symptoms your child displays and list the number of times per week the symptom is displayed:

Anger Anxiety Bedwetting Acts out sexually Conduct problems Controlling

Day defecation Has unusual sexual knowledge Day Wetting Defiance Depression

Homicidal thoughts or actions Disassociates Drug or Alcohol use Hyperactivity Masturbates excessively Hyper-vigilance Impaired conscience Isolation Lack of empathy Lack of motivation Lethargy Low impulse control Plays out violent themes Low self-esteem Lying Nightmares Plays out sexual themes Obsesses Over/Under eating Phobias Peer Problems Phobias Running away Shy Self-mutilating Sleeping problems Suicide talk Stealing Tantrums Somatic symptoms: headaches, stomachaches, etc OTHER Concerns:

_____

_____

_____

_____

Has the child experienced any significant loss? If Yes, Describe:

_____

How do you (parents) handle stress? What do you do to take care of yourself?

_____
_____
_____
_____
_____

What stressors do you have in your life now?

_____
_____
_____
_____
_____

How is your relationship with your spouse now?

_____
_____

_____
_____
_____

What do you view as your child's major strengths and positive traits?

_____

_____
_____

_____
_____

Describe your goals for your child's therapy:

_____

_____
_____
_____

What else is important for your therapist to know about your child and your family?

_____
_____
_____
_____
_____

_____
_____
_____
_____

Thank you for taking the time to complete this form. This information helps us have a strong start in helping your family.