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Child / Adolescent Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Email correspondence is not considered to be a confidential medium of communication. Please fill out this form and bring it to your first session.

PART I: Identifying Information

Child's Name: _____ D.O.B.:_____ Age: _____

Address: _____ City/State_____Zip_____

Gender: _____ Grade: _____ School: _____

Mother's Name: _____Phone: _____

Father's Name: _____Phone: _____

Parents' marital status: Married Divorced Separated Never Married Living Together

Who is the primary caregiver of the child? _____

If divorced, who has custody of this child? _____

Emergency Contact other than yourself:_____ Phone: _____

Name of person completing form: _____ Relationship to Child:_____

Part II: Reason for Referral

What is the main concern and what are some of the behaviors you observe that make you suspect there is a problem? And the frequency of the behaviors?

_____
_____
_____
_____

Does the problem occur at home? _____ School? _____ Other? _____

What makes things better? _____

What makes things worse? _____

What have you done to address the issues? _____

_____

Has this child seen a therapist or psychologist previously for any reason? Yes or No

If so, was it helpful? Who was the provider?

_____

_____

Part III: Social and Behavioral Questions

Place a check to any behavior or problem that your child currently exhibits:

_____Has difficulty with speech (articulation or producing sounds)
_____Has difficulty with hearing
_____Has difficulty with language
_____Has poor bowel/bladder control
_____Has difficulty with coordination
_____Sensitive to noises
_____Sensitive to touch
_____Picky Eater
_____Wets bed
_____Is too active
_____Is easily distractible/short attention span
_____Is fearful, of what:_____
_____Has frequent tantrums
_____Oppositional/defiant
_____Has frequent nightmares
_____Has trouble sleeping, can't fall asleep _____, can't stay asleep_____
_____Has poor appetite
_____Has memory problems
_____Has attachment problems, over attach_____, under attach _____
_____Boundary issues
_____Is aggressive, with whom _____
_____Is angry
_____Is impulsive
_____Is anxious
_____Decreased enjoyment in previously enjoyed activities
_____Does not get along with peers
_____Is sad or moody

Please use this space to describe any problems in more detail:_____
_____
_____
_____

How does this child get along with peers?

_____
_____

What is a typical day like for you / your child?

_____
_____
_____

PART IV: Family Information

Please list those persons who are important in your child's life:

_____

_____

Who currently lives in the home? Please include names and ages.

_____

_____

_____

What does your family do for fun?

_____

_____

What are this child's strengths? Skills? Hobbies?

_____

_____

Part V: Developmental History (if known)

During pregnancy, did the child's mother use any of the following:
____Tobacco ____Alcohol ____Medications ____Drugs

Any problems during the birth?: Y or N If so please explain: _____

Did your child meet developmental milestones on time? Examples: toilet training, crawling, sitting. Y or N

Part VI: Medical History

Have there been any health problems? _____ If yes, please explain:

_____

Has this child ever been hospitalized? Had surgery?

_____

Does this child have allergies? Y or N (please list)

_____

Medications: Please list any medications your child currently takes regularly:

Name _____

Frequency _____

Dosage _____

Physician name: _____

Part VII: Employment History

Has this child ever been employed? Y or N If yes, please explain:

_____

_____

Part VIII: Legal History

Has this child ever had difficulty with the police? Appeared in juvenile court or been on probation?
If yes, please explain:

_____

To your knowledge has the child ever used drugs or alcohol? Y or N If yes, please explain:

_____

_____

Part IX: Other Information

Please discuss anything else it would be important to know about the child:

_____

_____

_____

_____

If there is any history of abuse, trauma, neglect, witness to violence, death in the family, or family disruption, please explain:

_____

_____

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

Referred by (if any): _____

By signing this document, I am acknowledging that to my knowledge, the information provided is accurate and complete.

Client signature: _____ Date: _____

Parent/Guardian signature: ____Date: _____________________