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Child and Adolescent Intake

Today's Date:_____________________________ Completed by: _____ Mother_____Father_____Other

Child's Name:____Date of Birth:__________________________

Address:____

City:____State:__________________Zip_____________

Gender: ____ Grade in School: _________________________________

Ethnicity:

_____African American _____Bi-racial _____Hispanic/Latin

_____Asian _____Caucasian _____Native American Other _________________________________

Parent's Name:____

Address:____

City:____State:__________________Zip_____________

Home Phone:_______________________________________ Work Phone:____________________________________

Cell Phone:_______________________________________ Email:____

For confidentiality, when and where do you prefer to be reached? ____

May we text you? __________________________ May we email you? ____

**** Please note: Email and text messaging are not considered to be confidential mediums of communication.**

Parent's Name:____

Address:____

City:____State:__________________Zip_____________

Home Phone:_______________________________________ Work Phone:____________________________________

Cell Phone:_______________________________________ Email:____

For confidentiality, when and where do you prefer to be reached? ____

May we text you? __________________________ May we email you? ____

**** Please note: Email and text messaging are not considered to be confidential mediums of communication.**

Parent's Relationship Status: _____ Married _____ Never Married _____ Separated

______ Divorced _____ Partnered _____ Widowed

If divorced, who was granted legal right to make final decisions? ____

Please note: We require a copy of court documents regarding all custodial rights and privileges granted in cases of divorce.

Siblings (including half-siblings and step-siblings):

Name	Age	Gender
1.		
2.		
3.		
4.		

Others in home (Grandparents, cousins, family friends):

Name	Age	Gender
1.		
2.		
3.		
4.		

Significant Life Events in the Last Two Years:

_____ Death of a loved one _____ Divorce/Separation _____ Move/School Change

_____ Medical Problems (anyone in family) _____Family financial problems _____ Legal Problems (DUI, assault, etc)

_____ Remarriage/new step-siblings _____ Birth of new sibling _____Trauma (violence, natural disaster, accident)

_____Other____

Child's Strength's and Abilities

_____ Academic/Grades _____Sports _____Creative Arts (art or music, etc…) _____ Religious Involvement

____Group Involvement (Clubs, Organizations) _____ Sense of Humor _____Care for others

Other:____

____

Is there a history of previous treatment or any evaluations? ______ Yes _____ No

If so, when and by whom?

______ Educational evaluation:____

______ Psychological evaluation: ____

______ Outpatient therapy: ____

______ Hospitalization(s): ____

Does your child take medication? _____ Yes _____ No

If so, please list medication(s) and dosage (s):____

____

Who is the prescribing physician? ____

Child's Medical History

_____ Medical problems during pregnancy

_____ Maternal drug or alcohol during pregnancy

_____ Premature birth (if so, weight at birth: ______________________ gestational age: ______________________)

_____ Complications during birth (ex: Emergency C-Section, low oxygen, etc…)

_____ Stayed in neonatal intensive care (if so, how long?____________________________________)

_____ Health problems as a newborn or toddler

_____ Frequent ear infections

_____Asthma or allergies

_____ Head injuries, concussions, seizures, fevers over 104 degrees

_____ Serious accidents and/or hospitalizations

_____ Surgeries

_____ Problems with eating or sleeping

Child's Physician:____

Comments:____

____

Child's Developmental History

Has your child ever had any problems with?

_____Sitting up _____Walking _____Talking _____Toileting _____Bedwetting _____ Writing letters or scissors

_____ Reading or letter identification _____Physical coordination (running, jumping, climbing)

_____ Responding to discipline or behavior management _____Anger/temper tantrums _____Fears _____Sexual play

Other: ____

____

Child's Academic History

Current School: ____

School location: ____

Grade: ____Teacher(s): ____

Has your child…

_____ Repeated a grade _____Advanced grade _____Skipped school _____Been suspended _____Been expelled

_____Been bullied _____Stopped doing homework _____Been aggressive at school

_____ Received an IEP of 504 plan

_____ Received any special services ___OT ___PT ___ Reading ___Speech ___ Self-Contained Classroom

Other: ____

____

Child's Social Relationships

Does your child have a friend or friends outside the family? _____ Yes _____ No

Do you know them? _____ Yes _____ No

Do his/her friends tend to be: _____ Older _____ Younger _____ About the same age as your child

How well does your child get along with others?

____

____

Family History

Has anyone in your family struggled with (treated or untreated):

_____Depression

_____ Bipolar Disorder

_____ Learning problems (reading, math, spelling)

_____ Attention problems

_____ Excessive alcohol or drug use

_____ Sexual Abuse

_____ Physical Abuse

_____ Suicide attempts or completed suicide

Do you have any other concerns about your child? ____

____

____

How did you hear about our services? ____

____

____

What do you hope to accomplish in therapy with your child? ______________________________

____

____

What is your favorite quality about your child? ____

____

____