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Intake Form/ Child and Adolescent

Please fill out this form and bring it to your first meeting.

Child's Name:

(Last) (First) (Middle Initial)

Name of Parent/Guardian:

(Last) (First) (Middle Initial)

Parents' marital status (circle one):

Married | Divorced | Separated | Never married | Living Together

Birth Date: ____/____/____ Age: ____ Gender: Male Female

Address: _____

(City) (State) (Zip)

Home Phone: _____ May we leave a message? Y/N

Cell/Other: _____ May we leave a message? Y/N

Email: _____ May we e-mail you? Y/N

How were you referred to our office? _____

Do you have any siblings: Y/N If yes, please list ages:

Religious/Spiritual Beliefs: _____

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?

Does the problem occur at home? _____ school? _____ other?

Social and Behavioral Questions:

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

- Has difficulty with speech
- Has difficulty with hearing
- Has difficulty with language
- Has difficulty with vision
- Has poor bowel control
- Has difficulty with coordination
- Bed Wetting
- Is much too active / impulsive
- Is distractible / short attention span
- Is fearful
- Has frequent tantrums
- Oppositional / Defiant
- Has frequent nightmares
- Has trouble sleeping
- Has poor appetite
- Has memory problems
- Has attachment problems
- Is aggressive
- Is slow to learn
- Peer relationship problems

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

Does he/she have a problem controlling temper or with controlling anger? (describe)

Does he/she ever get sad or withdrawn? (describe)

How does this child react to stress or frustration? (describe)

Please describe how your child interacts with peers outside the home:

How does your child get along with other family members?

Does your child's behavior cause any difficulty within the family?

When was the problem first observed and by whom?

Has the child been evaluated for the current problem in the past?
(if yes, when and by whom)

Has your child previously received any type of mental health services in the past?
Y/N If yes, Previous therapist/practitioner and reason for treatment.

Was it beneficial?

Is your child currently taking any prescription medications at this time? If yes, please list below.

Any significant medical conditions? If yes, please list

Any history of alcohol/drug use? Y/N

Any history of psychiatric hospitalizations? Y/N If yes, please list dates and reason for treatment:

Household Occupants	Age	Relationship	Occupation	Lives with Child (Y/N)

Are there any known family genetic issues?

Has anyone in the family of either parent had any of the following problems?

	YES	NO	Relationship to Child
Learning problems in school	_____	_____	_____
Mental Retardation	_____	_____	_____
Sickle Cell	_____	_____	_____
Diabetes	_____	_____	_____
Blindness	_____	_____	_____
Seizures	_____	_____	_____
Alcoholism	_____	_____	_____
Depression	_____	_____	_____
Anxiety	_____	_____	_____
Birth Defect	_____	_____	_____
TB	_____	_____	_____
Cancer	_____	_____	_____
Deafness	_____	_____	_____
Cerebral Palsy	_____	_____	_____
Other:	_____	_____	_____
	_____	_____	_____

Is the child adopted Y/N: How long has the child lived in the current home?

When was the child placed outside the birth home? Why?

How many placements has the child had?

What were you told about the child's history?

Prenatal, Birth, and Developmental History

During pregnancy, did the child's mother use any of the following:

Tobacco _____ Alcohol _____ Medications _____

Drugs _____ Weight at Birth _____

Length of Labor _____ Type of Delivery: Vaginal _____ C-Section _____

Any Problems during the birth? Y/N

Full term: Y/N If not, how many weeks gestation?

Did the child breathe on his/her own at birth? Y/N Was oxygen required? Y/N

Explain: _____

This is a list of developmental milestones. Please give the approximate age when your child did reach the following. If the child cannot accomplish the item, please indicate by writing "no" in the space.

- | | | | |
|----------------|-------|------------------------|-------|
| Walking | _____ | Cooed | _____ |
| Talking | _____ | Understood No | _____ |
| Tie Shoes | _____ | Laughed Aloud | _____ |
| Toilet Trained | _____ | Gestures (waving) | _____ |
| Rolled Over | _____ | Followed one command | _____ |
| Sat Unassisted | _____ | Said first word | _____ |
| Crawled | _____ | Put two words together | _____ |

Medical History

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

Has he/she ever been hospitalized?

Has she/he ever had surgery?

Are his/her immunizations up to date? Y/N

Does he/she have allergies Y/N (please list)

Please list any medications your child takes regularly:

Physician Name: _____

Physician Telephone Number: _____

May I contact the physician to coordinate care if necessary? Y/N

Educational History

Name of school: _____ Grade: _____

Special education services Y/N

Has the child had any educational testing? Y/N

What grades does the child typically earn? _____

Does the child receive: Speech therapy _____ Occupational Therapy _____

Physical Therapy _____

Has the child been held back a grade? Y/N

Please check next to any educational problem that the child currently exhibits

- | | |
|---|---|
| <input type="checkbox"/> Has difficulty with reading | <input type="checkbox"/> Has behavior problems |
| <input type="checkbox"/> Has difficulty with arithmetic | <input type="checkbox"/> Does not like school |
| <input type="checkbox"/> Has difficulty with spelling | <input type="checkbox"/> Has difficulty with writing |
| <input type="checkbox"/> Does not get along with classmates | <input type="checkbox"/> Does not get along with teachers |

Legal History

Has the child ever had difficulty with the police? Y/N If yes, please explain:

Has the child ever appeared in juvenile court? Y/N If yes, please explain:

Additional Information:

What are the child's strengths?

What are the child's favorite activities?

What is the child's temperament like?
