# Child/Adolescent Intake Form

Name: _____ Date: _____

## PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

Please check all your child's behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Sadness/depression
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Fatigue
- ☐ Recurring, disturbing memories
- ☐ Change in appetite
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Phobias
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Racing thoughts
- ☐ Wide mood swings
- ☐ Suspicion/paranoia
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Defiance
- ☐ Aggression/fights
- ☐ Homicidal thoughts
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Peer/sibling conflict
- ☐ Stealing
- ☐ Destroys property
- ☐ Running away
- ☐ Swearing
- ☐ Curfew violations
- ☐ Lying
- ☐ Other:_____
- ☐ Manipulative behavior
- ☐ No/few friends
- ☐ Eating problems
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Toileting problems
- ☐ Fire setting
- ☐ Work/school problems
- ☐ Legal problems
- ☐ Sexual behavior
- ☐ Computer addiction
- ☐ Alcohol/drug use
- ☐ Lack of motivation

Are your child's problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Work/School
- ☐ Relationships
- ☐ Housing
- ☐ Hygiene
- ☐ Legal matters
- ☐ Health
- ☐ Finances

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt him/herself? If yes, please describe: _____

_____

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

_____

☐ Yes ☐ No Has your child recently been physically hurt or threatened by someone else? If yes, please describe: _____

_____

☐ Yes ☐ No Has your child gambled in the past 6 months? If yes, let us know the following

☐ Yes ☐ No Has your child ever felt the need to bet more and more money?

☐ Yes ☐ No Has your child ever had to lie to people about how much your child has gambled?

Therapist Notes:

Init: ____

Name: _____

## FAMILY AND DEVELOPMENTAL HISTORY

| Relationship | Name | Lives with Child? | Age | Quality of Relationship |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Stepmother | | | | |
| Stepfather | | | | |
| Siblings | | | | |
| | | | | |
| | | | | |
| | | | | |
| Other relatives | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Family Mental Health Problems | Who? |
|---|---|
| Hyperactivity | |
| Sexually Abused | |
| Depression | |
| Manic Depression | |
| Suicide | |
| Anxiety | |
| Panic Attacks | |
| Obsessive-Compulsive | |
| Anger/Abusive | |
| Schizophrenia | |
| Eating Disorder | |
| Alcohol Abuse | |
| Drug Abuse | |

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times ____
☐ Father remarried: Number of times ____

Please check if your child has experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

☐ Yes ☐ No Were there any medical problems during the pregnancy or birth of your child? If yes, please describe: _____

☐ Yes ☐ No Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? If yes, please describes substances used, quantity, and frequency: _____

☐ Yes ☐ No Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? If yes, please describe: _____

Therapist Notes:

Init: _____

Name: _____

## PREVIOUS MENTAL HEALTH TREATMENT

| Yes | No | Type of Treatment | When? | Provider/Program | Reason for Treatment |
|---|---|---|---|---|---|
| | | Outpatient Counseling | | | |
| | | Medication (mental health) | | | |
| | | Psychiatric Hospitalization | | | |
| | | Drug/Alcohol Treatment | | | |
| | | Self-help/Support Groups | | | |

Therapist Notes:

Init: ____

## SCHOOL INFORMATION

Current grade/placement: _____

| | | | | |
|---|---|---|---|---|
| This year's school grades: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| Past school grades: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| This year's school behavior: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| Past school behavior: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |

Has your child had any of the following difficulties at school?

☐ Suspension ☐ Incomplete homework ☐ Learning problems ☐ Referrals or detentions
☐ Poor grades ☐ Teased or picked on ☐ Speech problems ☐ Attendance problems
☐ Gang influence

☐ Yes ☐ No Does your child have an after-school provider? If so, who? _____

☐ Yes ☐ No Has your child ever repeated or skipped a grade? If yes, which one(s)? _____

☐ Yes ☐ No Has your child ever received Special Education services? If yes, please describe services received and reason for services: _____

What does your child's teacher(s) say about him/her? _____

Therapist Notes:

Init: ____

Name: _____

## SUBSTANCE USE HISTORY (for ages 12 and older or if applicable)

| Substance Type | Current Use (last 6 months) | | | | Past Use | | | |
|---|---|---|---|---|---|---|---|---|
| | Y | N | Frequency | Amount | Y | N | Frequency | Amount |
| Tobacco | | | | | | | | |
| Caffeine | | | | | | | | |
| Alcohol | | | | | | | | |
| Marijuana | | | | | | | | |
| Cocaine/crack | | | | | | | | |
| Ecstasy | | | | | | | | |
| Heroin | | | | | | | | |
| Inhalants | | | | | | | | |
| Methamphetamines | | | | | | | | |
| Pain Killers | | | | | | | | |
| PCP/LSD | | | | | | | | |
| Steroids | | | | | | | | |
| Tranquilizers | | | | | | | | |

☐ Yes ☐ No Has your child had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

☐ Yes ☐ No Has your child ever had problems with work, relationships, health, the law, etc. due to his/her substance use? If yes, please describe: _____

Therapist Notes:

Init: ____

## MEDICAL INFORMATION

Date of last physical exam: _____

Has your child experienced any of the following medical conditions during his/her lifetime?

☐ Allergies ☐ Asthma ☐ Headaches ☐ Stomach aches
☐ Chronic pain ☐ Surgery ☐ Serious accident ☐ Head injury
☐ Dizziness/fainting ☐ Meningitis ☐ Seizures ☐ Vision problems
☐ High fevers ☐ Diabetes ☐ Hearing problems ☐ Ear infections
☐ Miscarriage ☐ Abortion ☐ Sleep disorder ☐ Sexually transmitted disease
☐ Other: _____

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

| Medication | Dosage | Date First Prescribed | Prescribed By |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: ☐ None
If yes, please list: _____

Therapist Notes:

Init: ____

Name: _____

## INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your child's social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one? _____)

To which cultural or ethnic group does your child belong? _____
If your child is experiencing any difficulties due to cultural or ethnic issues, please describe: _____

How important are spiritual matters to your child? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much
☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your child's counseling?

Please describe your child's strengths, skills, and talents? _____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _____

Therapist Notes: _____

Init: ____

## LEGAL INFORMATION

If the parents are separated or divorced, what is the current child custody/visitation arrangement? _____

☐ Yes ☐ No Is your child currently the subject of a custody case?
☐ Yes ☐ No Has your child ever been a ward of the court with SCF/DCFS guardianship?
☐ Yes ☐ No Does your child have any legal offenses on record or pending in the courts?

Therapist Notes: _____

Init: ____