

Child/Teen Intake Form

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Patient's Age: _____ Patient's Gender: M F Patient's Cell (if driving self to sessions): _____

Mother's Name: _____ Occupation: _____ Date of Birth: _____

Mother's Phones: Home _____ Mom's Cell _____ Work _____
Okay to text/message? Y N Y N Y N

Father's Name: _____ Occupation: _____ Date of Birth: _____

Father's Phones: Home _____ Dad's Cell _____ Work _____
Okay to text/message? Y N Y N Y N

Primary Home Address: _____
Street City State Zip Code

Insurance Name: _____ ID#: _____ Insurer's Name: _____

Group #: _____ Insurance Phone: _____ Insurer's Date of Birth: _____

Family Information

Who are the patient's primary care givers? _____

Marital Status of Parents: ___Single ___Engaged ___Married (Years ___) ___Separated ___Divorced ___Widowed

If separated/divorced/widowed, how old was patient when this occurred? _____

How often does the patient see the parent who no longer lives in the home? _____

Were or are there any extenuating custody details/issues? _____

If remarried, how old was the patient when step-parent entered the family? _____

Names, Ages, Relationship to child of all people living in home:

Name	Sex	Age	Relationship to patient	Quality of Patient's relationship with person

Significant others not living in home: Specify relationship (full, half, step siblings, grandparents, bio-parent, etc.)

Name	Sex	Age	Relationship to patient	Quality of Patient's relationship with person

Presenting Problem

What seems to be your child's current difficulty? What concerns you at this time? _____

How long has this problem been a concern? (age/grade) _____

When was the problem first noticed? _____ Were there changes in his/her life at this time? **Y N**

If yes, describe: _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Has your child ever received an evaluation or treatment for the current problem or related/similar problems? **Y N**

If yes, when and with whom? _____

Current Information

Please check any events that have occurred within the past 12 months:

- | | | |
|---|---|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> School/Job Change | <input type="checkbox"/> Significant Friendship Changes |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Birth of Child in family | <input type="checkbox"/> Military combat assignment of family/friend |
| <input type="checkbox"/> Home Move | <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Death of close family member or friend |
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Natural Disaster | <input type="checkbox"/> Family Changes – people move in/out |
| <input type="checkbox"/> Custody Issues | <input type="checkbox"/> Bullying Issues | <input type="checkbox"/> Other: _____ |

Please check any current problematic behaviors & symptoms you notice in your child recently (past 12 months):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Self Harm Concerns |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Social Problems |
| <input type="checkbox"/> Alcohol/Drug | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fears/Phobias | <input type="checkbox"/> Judgment Errors | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Avoiding People | <input type="checkbox"/> Gaming/Cyber Addiction | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Career/College Decision | <input type="checkbox"/> Gender Identity Issues | <input type="checkbox"/> Memory Impairment | <input type="checkbox"/> Disorganized Thoughts |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hygiene Concerns | <input type="checkbox"/> Mood Shifts | <input type="checkbox"/> Disruptive Thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Homework Issues | <input type="checkbox"/> Pornography | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Stealing | <input type="checkbox"/> Worrying |
| | | | <input type="checkbox"/> Other: _____ |

Briefly describe how the above symptoms impact your child's ability to function (if old enough, child can complete):

Developmental History

Is your child adopted? **Y N** If yes, does your child know? **Y N**

Length of pregnancy (weeks)? _____ Length of delivery (hours)? _____ Age of Mother? _____

Did any of the following conditions occur during pregnancy or delivery?

Bleeding (excessive)	Y N	Excessive Weight Gain (more than 30 lbs)	Y N
Toxemia/Preeclampsia	Y N	Rh Factor Incompatibility	Y N
Serious Injury/Illness	Y N	Frequent Nausea/vomiting	Y N
Took Illegal Drugs	Y N	Took Prescription Medications _____	Y N
Drank Alcohol (___ drinks/week)	Y N	Smoked Cigarettes (___ cigs/day)	Y N
Epidural Used	Y N	Delivery was induced	Y N
Forceps Used	Y N	Other Problems	Y N
Had cesarean section	Y N	If yes, describe: _____	

Did any of the following conditions effect your child during delivery or within first few days after birth?

Injury during delivery	Y N	Cardiopulmonary distress	Y N
Umbilical Cord around neck	Y N	Trouble Breathing after Delivery	Y N
Needed Oxygen	Y N	Was cyanotic (turned blue)	Y N
Was jaundiced (turned yellow)	Y N	Was in hospital for more than 7 days	Y N
Had seizures	Y N	Was given Medications _____	Y N
Had an infection	Y N	Other Problems	Y N
Congenital Defect	Y N	If yes, describe: _____	

During the first 12 months, was your child?

Cheerful	Y N	Difficult to feed	Y N	Breast Fed	Y N
Affectionate	Y N	Difficult to get to sleep	Y N	Allergic	Y N
Alert	Y N	Difficult to keep busy	Y N	Very Stubborn	Y N
Sociable	Y N	Difficult to put on schedule	Y N	Colicky	Y N

Did your child accomplish developmental milestones within the normal time frame?

Sitting w/o help	Y N	Walking by self	Y N	Bladder Training	Y N
Crawling	Y N	Talking	Y N	Bowel Training	Y N

Educational History

Name of School: _____ Current Grade: _____ Years @ School District: _____

Was your child enrolled in an early childhood program? **Y N** If yes, describe/name: _____

Is your child currently failing or at risk of failing any subjects? **Y N** If yes, describe: _____

Has your child ever failed a grade or been retained? **Y N** If yes, describe: _____

Does your child receive any special educational services? **Y N** If yes, describe: _____

Has your child received special educational services in the past? **Y N** If yes, describe: _____

Describe any significant events/problems at your child's current school or at a previous school: _____

How does your child feel about school? _____

Has s/he always felt this way? **Y N** If no, what is different? _____

Medical History

Primary Doctor's Name: _____ Phone #: _____ City: _____

Other Doctor's Name: _____ Phone #: _____ City: _____

Is your child currently being treated for a medical illness? **Y N** If yes, what? _____

Date of your child's last physical exam: _____

Describe your child's vision: ___Normal ___Corrected due to vision of 20/___ Date of last exam: _____

Describe your child's hearing: ___Normal ___Corrected with aides/implants Date of last exam: _____

Has your child ever had counseling? **Y N** If yes, with whom? _____

If yes, what was successful? _____

If yes, what was not helpful? _____

Has your child had psychological testing? **Y N** If yes, by whom? _____

If yes, what diagnosis was given? _____

Is your child currently taking any medications? If yes, describe: _____

Has your child taken medications in the past (for chronic issue)? If yes, describe: _____

Does your child have or has s/he had any of the following medical conditions?

Asthma	Y N	Head Injury with loss of consciousness	Y N
Allergies	Y N	Surgery or lengthy hospitalization	Y N
Diabetes/arthritis/other chronic illnesses	Y N	Chronic ear infections	Y N
Epilepsy or seizure disorder	Y N	Fine motor or handwriting problems	Y N
Heart or blood pressure problems	Y N	Gross motor difficulties, clumsiness	Y N
High Fevers (over 103 degrees)	Y N	Appetite problems (over or under eating)	Y N
Broken Bones	Y N	Sleep problems (falling or staying asleep)	Y N
Severe cuts requiring stitches/staples	Y N	Soiling problems	Y N
Drug or Alcohol use/addiction	Y N	Wetting problems	Y N

Please describe any other health difficulties not noted above:

Please note any illnesses or conditions that any immediate, blood-related family member has had (note relationship):

Academic problems	Y N	_____	Cancer	Y N	_____
ADHD	Y N	_____	Diabetes/Thyroid Issues	Y N	_____
ODD or Conduct Disorder	Y N	_____	Epilepsy/Seizures	Y N	_____
Depression	Y N	_____	Heart/Blood Trouble	Y N	_____
Anxiety	Y N	_____	Neurological disease	Y N	_____
Alcoholism/Drug Addiction	Y N	_____	Developmental problems	Y N	_____
Suicide Attempt	Y N	_____	Other Problems	Y N	_____

Please check if there have been any recent changes in the following for your child:

___ Sleep Patterns	___ Behavior	___ Energy Level	___ General Disposition
___ Eating Patterns	___ Weight	___ Physical activity level	___ Nervousness/tension

Describe any checked items above:

Behavioral History

In one or two sentences, please describe your child's behavior and general attitude while at home.

How does your child respond to frustration, failure or success (i.e.: shut down, act out, withdraw, in your face, etc.)?

How does your child communicate that something is bothering him/her?

What is your child's approach to difficult tasks (especially tasks that are typically not enjoyable)?

Please describe your child's interactions with peers (i.e.: appropriate, threatening, withdrawn, annoying, etc.).

Please describe your child's interactions with you (i.e.: appropriate, defiant, attention seeking, argumentative, etc.).

What strategies have you found to be particularly EFFECTIVE with discipline/rewarding your child?

What strategies have you found to be particularly INEFFECTIVE with discipline/rewarding your child?

Please list any duties/chores your child is responsible for at home:

How often is each completed?

Approximately how many close friends does your child have currently? _____

How much time does s/he spend with friends outside of school hours? _____

What hobbies or extracurricular activities does your child participate in? _____

How much time is spent on hobbies/extracurricular activities (hours/week)? _____

Has your child ever been in trouble with the law? **Y N** If yes, describe: _____

Who does your child look up to or is closest to? _____

Anything else about your child's behavior that you feel is important to share? (Please use back side of sheet.)

Please list behaviors/competencies that you would like to see your child develop as a result from counseling.
