Child/Adolescent Intake

Child Name:_____ DOB:_____

Address:_____ City:_____ Zip:_____

Sex: ☐ Male ☐ Female Age: _____

School attending_____ Grade (current or entering) _____

Is patient adopted? Yes No If yes, at what age? _____

Race/Ethnicity

☐ Caucasian ☐ Native American ☐ Multiracial _____

☐ African American ☐ Asia ☐ Latin or Spanish ☐ Other _

Biological Parents (or Guardian information):

Are Biological parents divorced or separated? Yes No If yes, for how long _____

If yes, do parents share custody? Yes No ** Court documentation must be provided

Parent:_____ Relationship_____

Phone:_____ okay to leave msg? ☐ Yes ☐ No

Occupation:_____

Email:_____ okay to use email? ☐ Yes ☐ No

Co-Parent:_____ Relationship_____

Phone:_____ okay to leave msg? ☐ Yes ☐ No

Occupation:_____

Email:_____ okay to use email? ☐ Yes ☐ No

Insured Party (for patient)_____ DOB:_____ Ins. Provider_____

Siblings (include biological, adopted, foster, step, etc.)

Name	Sex	Age	Type (bio,step,etc.)	Custody?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Anyone else living in your household other than parents or siblings? Yes No

***If yes, please give name(s) and relationship:

_____

Person to contact in case of emergency: Phone Number:

COUNSELING HISTORY OF CHILD/ADOLESCENT

Prior counseling experience:

From:_____ To:_____ With Whom? _____

How were you referred to me? _____

Is there any history of mental health issues in family? (if yes, please describe) _____

_____

Basic Health ☐ Good ☐ Fair ☐ Poor Date of last exam? _____

Physician's Name:_____ Phone: _____

Is child/adolescent taking any prescription medication at this time? ☐ Yes ☐ No

If yes, what? _____

Is child/adolescent taking any over the counter medication at this time? ☐ Yes ☐ No

If yes, what? _____

Current reason for seeking counseling

Are there any physical, emotional, or mental issues now or in the past that I need to be aware of ? Yes / No

If yes, what? _____

Has child/adolescent ever been hospitalized? Yes / No

If yes, for what and when _____

Briefly describe the problem for which you wish your child/adolescent to have counseling:

_____

_____

_____

The thing that concerns me most right now is: _____

_____

_____

_____

Counseling would be successful if: _____

_____

I understand that suicidal threats, homicidal threats or child abuse will be reported.
I understand that the parent must facilitate the ability for child/adolescent to trust the therapist and will respect confidentiality when appropriate.

Parent(s) Print names: _____ _____

Signatures: _____ _____

Adolescent Signature: _____

Initial Service Plan

Please check any of the reasons listed below which resulted in your coming in today:

- ☐ Depression or Anxiety
- ☐ Alcohol or other drug abuse
- ☐ Communication Difficulties
- ☐ Harm to self or others
- ☐ Abuse (physical/verbal/sexual)
- ☐ Sexual Orientation Questions
- ☐ Child Adjustment/Parent Conflict
- ☐ Divorce
- ☐ Adoption
- ☐ _____
- ☐ Difficulty with loss or death
- ☐ School adjustment problems
- ☐ School learning difficulties
- ☐ Low Self Esteem/social withdraw/motivation
- ☐ General Defiance
- ☐ Staying Focused/Task Completion
- ☐ Eating Disorder/Obesity
- ☐ Individual Counseling
- ☐ Family Counseling
- ☐ _____

What event happened which made you think "I am (we are) calling a therapist?" _____

_____

_____

Modality – who would you like to see participate in counseling?:

_____

_____

_____

What behaviors would you like to change? _____

_____

_____

Patient's strengths and interests: _____

_____

_____

Specific Goals identified (can be completed with therapist) Plan Review Date: 6 months from intake

_____

_____

_____

_____

Patient Name_____ Signature_____Date _____

Parent/Legal Guardian Name_____Signature_____Date _____

Therapist Name_____Signature_____Date _____