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Child and Adolescent Intake Form

Please complete this form with as much information as possible. It will help me in working with your child.

Child's Name:_____ Gender:_____ D.O.B:_____

Birth Place:_____ Age:____ School:_____ Grade ___

Name of Parent/Caregiver:_____ D.O.B:_____

Address:_____

Place of Employment: _____ Occupation:_____

Telephone: Home:_____ Work:_____ Cell:_____

Name of Parent/Caregiver:_____D.O.B.:_____

Address:_____

Telephone: Home:_____ Work:_____ Cell:_____

Place of Employment: _____Occupation:_____

Call In Emergency: _____
Name Number Relationship to child

How did you hear about my services? _____

Insurance Company: _____ Policy Number: _____

Name of Primary Insured: _____

Are both parents living in the same household? YES NO

If no, please explain living arrangement/visitation with each parent/caregiver:

_____

Other people living in the home:

_____

_____

List concerns you or others have about your child: (When did they begin? How do they affect your family/your child at home, school, etc.)

_____

_____

_____

_____

_____

_____

Siblings: (name/age & brief description of child's relationship with the sibling)

Name	**Age**	**Type of Relationship**

_____

_____

_____

_____

Primary care doctor:

_____

Name **Address** **Phone Number**

Specialty doctors/providers:

_____

_____

Name **Specialty** **Address** **Phone Number**

Medical issues: (include head injuries, surgeries, accidents, falls, illness, allergies to food or medications etc.) _____

_____

_____

List all medications the child is taking, dose and reason for medication:

_____

Doctor prescribing the medication: _____

List all psychotropic medications child has taken in the PAST: (Reason for taking and the reason for discontinuing):

_____

_____

Past therapists:

Name	Dates Seen	Reason for Therapy	Helpful?
			Y__N___
			Y__N___
			Y__N___

Family medical history: (List health issues in child, parents or extended family)

_____

_____

List mental health issues of family members: (eating disorder, depression, anxiety, OCD, bipolar disorder, schizophrenia etc.)

_____

_____

_____

Has anyone in the family ever attempted suicide or completed a suicide? If so, who and when?

_____

_____

Has your child or anyone in the family (including extended family) abused alcohol or other substances? If so, please list who and how this has impacted the family.

_____

_____

Is anyone in your family (including extended family) in recovery for substance abuse? If so, who and how long?

_____

Please list any trauma your child has experienced: (accidents, witnessing violence, death of a loved one or pet, separation from a caregiver, bullying etc.):

_____

_____

_____

_____

List any physical, sexual or emotional abuse your child has experienced: (at what age and by whom): Please note that limits of confidentiality apply here so only answer if comfortable _____

_____

_____

If yes, was this reported and did they receive any treatment for the abuse?

_____

School behavior and academic functioning: (grades, relationships with peers/teachers, friendships, how your child feels about school, any school fears):

_____

_____

_____

_____

_____

Does your child receive special education services? (type/when they started):

_____

School/extracurricular activities: _____

_____

_____

_____

Your child's strengths: _____

Your family's strengths:

Who does your child go to for comfort or help? _____

What You Would Like To See Change: _____

Any concerns about your child that I did not ask about?