CLIENT NAME: DATE:

CHILD/ADOLESCENT INTAKE FORM

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

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

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

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

Self esteem	Handling everyday tasks	Relationshiops	Hygiene	Health
Work/school	Recreational activities	Legal matters	Housing	Finance

CLIENT NAME: DATE:

Has your child ever had thoughts, made statements, or attempted to hurt him/herself? □ Yes □ No

If yes, please describe: _____

Has your child ever had thoughts, made statements, or attempted to hurt someone else? □ Yes □ No

If yes, please describe: _____

Has your child recently been physically hurt or threatened by someone else? □ Yes □ No

If yes, please describe: _____

Has your child gambled in the past 6 months? If yes, please 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? □ Yes □ No

Therapists Notes: Initial_____

FAMILY AND DEVELOPMENTAL HISTORY

RELATIONSHIP	NAME	LIVES WITH CHILD?	AGE	QUALITY OF RELATIONSHIP
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Other relatives				

CLIENT NAME: DATE:

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 Mother remarried: Number of times: _____

□ Parents temporarily separated Father remairried: Number of times: _____

□ Parents divorced or permanently separated

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

Emotional abuse Neglect Lived in a foster home Sexual abuse

Violence in the home Homelessness Multiple family moves Physical abuse

Teen pregnancy Parent illness Parent substance abuse Crime victim

Financial problems Loss of a loved one Placed a child for adoption

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

CLIENT NAME: DATE:

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? □ Yes □ No If yes, please describe: _____

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

SCHOOL INFORMATION

Therapist Notes:
Initial: _____

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	Poor grades
Speech problems	Referrals or detentions	Teased or picked on	Gang influence
Attendance problems			

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

Has your child ever repeated or skipped a grade? □ Yes □ No If yes, which ones? _____

Has your child ever received Special Education Services? If yes, please describe services received and reason for services: _____

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

Does your child currently engage with the school counselor? □ Yes □ No

If so, what is the name of this counselor? _____

CLIENT NAME: DATE:

Therapists Notes: Initial_____