CHILD AND TEEN INTAKE FORM

Dawn Wilcox, LCSW Jill Berlin, LCSW Kate Thomas, LMFT Stacy Horne, LCSW

Name of Client _____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

School_____ Grade_____

Teacher _____ School Counselor_____

Mother's Name_____

Address _____Town _____ Zip _____

Cell phone number _____ alternate number _____

Email address _____

_____Yes email me appointment reminders or _____No thank you

Father's Name_____

Address (if different from above)_____Town _____

Zip _____

Cell phone number _____ alternate number _____

Email address _____

_____Yes email me appointment reminders or _____No thank you

If parents are separated/divorced, please explain specific custody status

Please explain visitation schedule if parents are separated/divorced

Are both parents in agreement for child's need for therapy? _____yes _____ no

Emergency Contact information-
Please list a name of someone other than parent in case of emergency

Name _____ relationship to client _____ phone _____

MEDICAL HISTORY

Name of Primary Care Physician:_____

Physician's Address:_____Physician's Phone:_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES / NO

Please sign here for either answer: _____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken:

1)_____Dosage/Freq _____ Start Date_____Purpose_____

2)_____Dosage/Freq _____ Start Date_____Purpose_____

3)_____Dosage/Freq _____ Start Date_____Purpose_____

4)_____Dosage/Freq _____ Start Date_____Purpose_____

Prescribed by:

_____

Has your child ever been hospitalized for medical or psychiatric reasons? (Circle one) YES / NO
Hospital Name, Mo/Yr, Reason: _____
_____

Describe any important medical history, chronic ailments, or other health problems your child experiences:_____
_____
_____

Does your child have a learning or physical disability? (Circle One) YES / NO MAYBE. Describe:_____
_____

Does your child have a mental health diagnosis? (Circle One) YES NO MAYBE. Describe:_____
_____

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments: _____
_____
_____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____
_____
_____
_____
_____

DEVELOPMENTAL and FAMILY HISTORY

In the first two years of life, did your child experience:

___Separation from mother, ___Out of Home care, ___Disruption in bonding, ___Depression of mother,

___Abuse, ___Neglect ___Chronic pain, ___Chronic Illness, ___Parental Stress

Reached developmental milestones: ___On Time, ___Early, ___Late

How many times has the child moved homes? _____

What are five adjectives that describe:

Mother:_____

Father:_____

Child:_____

Parental Relationship:_____

Biological Dad:_____ DOB:_____ Biological Mom:_____DOB: _____

Married: __/__/__; Separated: __/__/__; Divorced: __/__/__

Siblings (1st to last) Name: _____ Age _____

Name: _____ Age _____ Name: _____ Age _____

Name: _____ Age _____ Name: _____ Age _____

Custodial Adults (if not biological parents): Dad: _____ DOB:_____

Mom: _____ DOB:_____ Date became caretaker: _____

People in household, if different from above:

_____

_____

Does father work outside the home? ___ Yes ___ No; Occupation: _____ Hours: _____

Father's highest level of education? _____

Does mother work outside the home? ___ Yes ___ No; Occupation: _____ Hours: _____

Mother's highest level of education? _____

If separated or divorced, visitation schedule:_____

Does either parent have legal issues? If YES, Describe_____

Does your family have any specific spiritual or religious beliefs? If YES, Describe _____

_____

List any mental illness or addiction in immediate or extended family (For example: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, eating disorders, ADHD, Schizophrenia) _____

_____

Have your children witnessed domestic violence? ___Yes ___No. If Yes, describe:_____

_____

How is your child disciplined? Please list each method and frequency of use: _____

_____

_____

ACADEMIC AND SOCIAL HISTORY

ACADEMIC PERFORMANCE

Highest grade on last report card? _____

Lowest grade on last report card? _____

Favorite subjects in school?_____

Least favorite subjects?_____

Has your child had special testing in school? (If YES, please describe below)

Psychological ____YES ____NO Learning ____YES ____NO Vocational ____YES ____NO

_____

_____

What would your child life to do about school at this point?

____Quit school ____Graduate from High School ____Go to College

In school, how many friends does your child have? ____ a lot ____a few ____none

Does child have friends in the neighborhood or close cousins they play regularly with? ____YES ____NO

Describe:_____

_____

How does your child handle anger with peers and family?_____

_____

_____

What are your child interests, hobbies and regular activities?_____

_____

_____

_____

_____

How much time does your child play on the computer, watch TV or play video games? _____

_____

Has your child ever had difficulty with the Police?

_____

_____

Has your child ever appeared in Juvenile Court?

_____

Has your child ever been on Probation?

Dates	Reason	Probation Officer
_____	_____	_____
_____	_____	_____

Has your child ever been employed?

Dates	Employer	Job
_____	_____	_____
_____	_____	_____

TRAUMA HISTORY

Has your child been verbally abused? ___Yes ___No ___Suspected Describe: _____

_____

Has your child been physically abused? ___Yes ___No ___Suspected Describe: _____

_____

Has your child been sexually abused? ___Yes ___No ___Suspected Describe: _____

_____

Other stressors or traumas? _____

_____

CONCERNS, STRENGTHS AND GOALS

Circle the symptoms your child displays and list the number of times per week the symptom is displayed:

Anger	Anxiety	Bedwetting	Acts out sexually
Conduct problems	Controlling	Day defecation	Has unusual sexual knowledge
Day Wetting	Defiance	Depression	Homicidal thoughts or actions
Disassociates	Drug or Alcohol use	Hyperactivity	Masturbates excessively
Hyper-vigilance	Impaired conscience	Isolation	Lack of empathy
Lack of motivation	Lethargy	Low impulse control	Plays out violent themes
Low self-esteem	Lying	Nightmares	Plays out sexual themes
Obsesses	Over/Under eating	Phobias	Peer Problems
Phobias	Running away	Shy	Self-mutilating
Sleeping problems	Suicide talk	Stealing	Tantrums

Somatic symptoms: headaches, stomachaches, etc

OTHER Concerns:_____

_____

Has the child experienced any significant loss? If Yes, Describe:_____

_____

What do you view as your child's major strengths and positive traits? _____

_____

_____

Describe your goals for your child's therapy:_____

_____

_____

What else is important for your therapist to know about your child and your family? _____

_____

_____

Thank you for taking the time to complete this form. This information helps us have a strong start in helping your family.