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Intake information for children/adolescents

To make the best use of your session, please fill out this form and mail it before your appointment. If your appointment is within a few days, please bring the form with you. If you prefer not to answer a question, leave it blank; if a question does not apply to your child's situation, write "NA."

Today's date: ______________________

Child's name ____ Sex _______

Date of birth _____________ Nickname ______________________________

Address ____

School ____ Grade_______________

FAMILY INFORMATION:

Who is raising the child? (Check appropriate answer)

Biological parents____ Parent and step parent____ Single parent____ Foster parent/s____

Adoptive parent/s____ Relatives____ Other (explain) _______________________________

Describe the people the child currently lives with:

Primary caregiver 1: Name ________________________________ Date of birth _________________

Relationship to child:

____

Home phone ___________________________ Ok to leave message? Yes____ No____

Cell phone _____________________________ Ok to leave message? Yes____ No____

Work phone ____________________________ Ok to leave message? Yes____ No____

Email address ____(Please note that email is not considered a confidential medium for communication)

Occupation ____

Employer ____

Please list any history of mental illness or addiction in immediate or extended family of **caregiver 1** (e.g., depression, anxiety, bipolar disorder, suicide attempts, alcoholism, drug abuse, schizophrenia, etc.)____

____

Primary caregiver 2: Name ________________________________

Date of birth ________________

Relationship to child: ____

Home phone ___________________________ Ok to leave message? Yes____ No____

Cell phone _____________________________ Ok to leave message? Yes____ No____

Work phone ____________________________ Ok to leave message? Yes____ No____

Email address ____ (Please note that email is not considered a confidential medium for communication)

Occupation ____

Employer ________________________

Please list any history of mental illness or addiction in immediate or extended family of **caregiver 2** (e.g., depression, anxiety, bipolar disorder, suicide attempts, alcoholism, drug abuse, schizophrenia, etc.)

____

____

If the child was adopted –

Child's age at adoption ______________________

Date of adoption ______________________

Does the child know that he/she was adopted? ____

Reaction of the child to adoption ____

If the child is a foster child –

Agencies involved: ____

____

Child's age when placed into foster care _____________

Reason for foster placement:

____

Child's reaction to placement

____

Are there other children in the family? Yes____ No____

Names and ages of other children: ____

____

Child's medical and psychological history

Child's physician's name and phone number

____

Date of last physical ____________________

Has child ever been hospitalized? Yes____ No____ (If yes, please state dates and reasons)

____

____

Does your child have any significant health problems? Yes____ No____ (If yes, please specify)

____

____

Does your child have a mental health diagnosis? Yes____ No____ (If yes, please specify)

____

____

Has your child been diagnosed with a learning disability? Yes____ No____ (If yes, please specify)

____

____

Has your child experienced any significant trauma or loss? Yes____ No____

If yes, please explain

____

____

Please list all medications your child takes (name of medication, dosage, and purpose)

____

____

Does child use: cigarettes ____ alcohol_____ illegal drugs ________

(Please specify amount and frequency) ____________________________

Please check all symptoms that your child is experiencing:

_____ overeating □
_____ theft/destruction of property □
_____ compulsive behaviors □
_____ restricting food□
_____ depressed mood □
_____ learning difficulties □
_____ fears/phobias □
_____ odd behavior/thoughts □
_____ crying □
_____ trembling or shaking □
_____ anxiety □
_____ recent weight gain □
_____ difficulty concentrating □
_____ worrying □
_____ vomiting □
_____ recent weight loss □
_____ low motivation □
_____ toileting problems □
_____ distrust □
_____ recent appetite changes □
_____ aggressive/angry behavior □

_____ lying □
_____ jumpiness □
_____ social withdrawal □
_____ feelings of worthlessness □
_____ nightmares □
_____ defiance□
_____ suicidal thinking □
_____ impulsive/risky behavior □
_____ language difficulties □
_____ fatigue/loss of energy □
_____ hyperactivity □
_____ sleeping too much □
_____ decreased need for sleep □
_____ obsessions □
_____ difficulty falling asleep □
_____ problems at school □
_____ non-compliance □
_____ social problems □
_____ difficulty staying asleep □
_____ inattention/easily distracted □

_____ other: ____

Has child experienced:

_____ parent separation or divorce
_____ arguments/fights between parents
_____ death of family member
_____ hospitalization of family member
_____ loss or death of friend
_____ loss or death of pet
_____ frequent moves
_____ other upsetting events
(please specify)____

____

Child's early history: Weight at birth _____________

Weeks gestation____________________

Any complications of pregnancy, labor or delivery?

____

____

____

At what age did child: sit unassisted ________ walk unassisted___________

speak first words ________ At what age did toilet training begin? ______________

When was child finally toilet trained? ___________

Any problems after child completed toilet training? At what age?

____

Describe temperament as an infant/young child____

____

School concerns. Any problems in daycare, preschool, elementary, middle school, high school? If **yes,** please describe child's adjustment, any special classes, typical grades, social concerns, etc.

Daycare ____

____

Preschool ____

____

Elementary school ____

____

Middle school____

____

High school ____

____

Counseling concerns

How would you describe child's relationship with primary caregivers?____

____

How would you describe child's relationship with siblings or other members of household?

____

____

How would you describe relationship between primary caregivers?

____

____

What are your goals for your child's psychotherapy?

____

____

Has your child received psychotherapy in the past? If yes, when and with whom?

____

Has the child ever had a psychological, educational, neurological or other evaluation?

Yes____ No____

If yes, please list dates and names of providers:

____

____

Note: It would be very helpful to bring copies of any evaluations to your child's first appointment)

What do you see as your child's major strengths?____

____

Is there anything not on this form that would be useful for me to know in helping your child?

____

____

____