Intake Information-Child/Adolescent

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to the child's first session.

Date: _____

Social Security Number: _____-_____-_____

Name:

_____

(Last) (First) (Middle Initial)

Name of parent/guardian:

_____

(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Address:_____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: _____-_____-_____ May we leave a message? _Yes _No

Cell/Another Phone: _____-_____-_____ May we leave a message? __Yes __No

Email: _____ May we email you? __Yes __No

*Please note: Email correspondence is not considered to be confidential medium of communication.

Referred by (if any): _____

Method of Payment:
(Please check all that apply)

Medicaid ____Medicaid Number _____

CPS ____Caseworker: _____

Insurance _____ Policy Number/Carrier _____
Insurance Phone Number: _____

Private Pay (cash, check, or credit card): _____

Crime Victims: _____

Information:

Has the child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? __No __Yes, previous therapist/practitioner: ____

Is the child currently taking any prescription medications? __No __Yes

Please List:

_____

_____

Has the child ever been prescribed psychiatric medication? __No __Yes

Please list and provide dates:

_____

_____

Name of physician who monitors medication: _____

Name and describe any medical condition which affects the patient:

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate the child's current physical health? (please circle one)
   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific health problems the child is currently experiencing:

   _____

2. How would you rate the child's current sleeping habits? (please circle one)
   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific sleep problems the child is currently experiencing:

   _____

3. How many times per week does the child generally exercise? _____
   What types of exercise does the child participate in? _____

4. Please list any difficulties the child experiences with their appetite or eating patterns:

   _____

5. Is the child currently experiencing overwhelming sadness, grief, or depression: __No __Yes
   If yes, for approximately how long? _____

6. Is the child currently experiencing anxiety, panic attacks or have any phobias? ___No __Yes

   If yes, when did they begin to experience them? _____

7. Is the child currently experiencing any allergies? ____No ____Yes
   If yes, please describe _____

8. Has/does the child/adolescent engaged in recreational drugs? __No __Yes
   If yes, how often? _____

9. What significant life changes or stressful events has the child experienced recently:

   _____

   _____

   _____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to the child in the space provided (father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes/No	_____
Anxiety	Yes/No	_____
Depression	Yes/No	_____
Domestic Violence	Yes/No	_____
Eating Disorders	Yes/No	_____
Obesity	Yes/No	_____
Obsessive Compulsive Disorder	Yes/No	_____
Schizophrenia	Yes/No	_____
Suicide Attempts	Yes/No	_____

ADDITIONAL INFORMATION:

1. Is the child currently attending school? ___No __Yes
   If yes, what school do they attend and what grade?

   _____

Does the child enjoy school? Is there anything stressful about attending school? Describe their school performance.

_____
_____
_____

2. If parents do not live with child, how often does the parent see the child?
   _____
3. Please state who has custody of the child: _____

4. Do you consider the child to be spiritual or religious? __No __Yes
   If yes, describe the child's faith or belief: _____

5. What do you/child consider to be some of the child's strengths?
   _____
   _____
   _____
   _____

6. What do you/child consider to be some of the child's weaknesses?
   _____
   _____
   _____
   _____

7. What would you/child like to accomplish out of their time in therapy?
   _____
   _____
   _____
   _____