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Child/Youth Intake Form

Name: _____
First Middle Last

Gender/Pronouns: _____ Current Age: _____ Birth date: _____/____/_____

Is it okay to leave a message? _____ Home: _____ Work: _____

Cell: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Name and relationship of person bringing in client: _____

_____

Referred by: _____ Relationship: _____

Insurance name: _____

Insurance phone number: _____

Claims address: _____

Subscriber name and date of birth: _____

Subscriber ID: _____

Name of client's parents: _____

Parent's marital Status: Single Engaged Married Divorced
Separated Living Together Remarried Widowed

Parent's Occupations: _____

In case of emergency contact: _____

Phone: _____ Relationship: _____

People who currently live in child/adolescent's household:

Name	Sex	Age	Relationship

Reason for seeking help at this time:

Significant people or family members not currently living with Child/ Adolescent:

name	gender	age	relationship

Please check each item that is a concern for your child/adolescent:

__ Appetite/weight
__ Bowel problems
__ Depression
__Low energy
__Feeling inferior
__Work
__Concentration
__Anger
__Children
__Nervousness
__Legal matters
__Nightmares
__Alcohol use
__Separation
__Moves
__Abuse, physical
__Neglect
__Other changes
__Stomach aches
__Headaches
__Loneliness
__Unhappiness
__Shyness
__Career
__Education
__Temper
__Discipline
__Stress
__Finances
__Dreams
__Thoughts
__Marriage
__Deaths
__Abuse, sexual
__ Visitation/custody
__ Other: _____
__Health problems
__Sleep-too little/much
__Suicidal thoughts
__Tiredness
__Making decisions
__Ambition – to little/much
__Difficulty relaxing
__Self-control
__Being a parent
__Fears
__Friends
__Memories
__Drug use
__Sexual problems
__Other losses
__ Abuse, verbal

Circle symptoms your child has and number of times per week:

Anxiety___	Anger__	Overeating__	Acts out sexually with others____
Bedwetting__	Defiance__	Under eating__	Masturbates excessively__
Day wetting__	Controlling__	Sleeplessness__	Unusual or excessive sexual knowledge_
Accidents__	Lack of empathy__	Nightmares__	Plays out sexual themes___
Obsesses__	Lying__	Hyper vigilance__	Plays out violent themes __
Depression__	Low impulse control_	Startles easily__	Homicidal themes or actions__
Low energy__	Stealing__	Fears/Phobias__	Suicidal thoughts or actions___
Shy__	Drug/alcohol use__	Running away__	Stomach aches/ head aches __
Tantrums__	Impaired conscience_	Peer problems__	Spacing out____
Violent__	Excessive crying__	Low concentration__	Feelings of inferiority__
Grief__	Putting self down__	Memories____	Academic problems__
Allergies __	Specific Fears_____		Hallucinations (hearing/seeing things)__

Other_____

Has your child ever been in counseling before? If so, when? Was it helpful? Who was the therapist? _____

_____

What changes would you or your child/adolescent like to see as a result of counseling?

_____

_____

_____

_____

What Strengths do you see in your teen's personality? (ie intelligence, compassion, creativity….)

_____

_____

_____

_____

_____

Health History:

Overall Health condition of child/ adolescent: very good good average poor

Comments: _____

_____

_____

Significant medical conditions: _____

Hospitalizations: _____

Medications currently taking: _____

Primary Care Doctor: _____

Prescribing Doctor/Psychiatrist: _____

School History:

Name/location of school child/adolescent is attending: _____

Grade: _____ Average Grade Point: _____

Has your child/adolescent's behavior ever been a concern of one of his/her teachers? Describe:

_____

_____

_____

Does your child/adolescent have any difficulties learning? _____

_____

Does or did your child/adolescent have any difficulties at school with any of the following:
writing reading arithmetic poor coordination memories of letters or numbers
making friends bullying being bullied keeping friends concentration

What are your child/adolescent's strengths in school? _____

_____

Legal History:

Are there custody disputes or current custody arrangements in place for the child/adolescent?

_____

_____

_____

Are there any restraining orders in place that affect the child adolescent? Describe: _____

_____

_____

Is child/adolescent currently on probation or parole: Y N

Are any family members currently on probation or parole or currently incarcerated? Describe:

_____

_____

_____

Family History:

Please describe the quality of home life (ie: happy, tense, communication issues, stability, security, abuse, etc.): _____

_____

_____

Does the family or child/adolescent have any religious affiliation? _____

What is the cultural background of the child/adolescent? _____

What types of discipline are used within the family? _____

_____

Describe the relationship between the child/adolescent's parents: _____

_____

_____

Describe how the child/adolescent gets along with others within the family: _____

_____

_____

Is there a history of mental illness, or emotional problems within the family or extended family?

_____

_____

Please list anyone in the child/adolescent's family, including the child/adolescent and extended family that used or uses alcohol or drugs (prescription or recreational drugs):

relationship to child types of drugs purpose for how long

_____

_____

_____

_____

_____

Personality of Child/Adolescent:

tense relaxed restless calm daydreamer self starter active sluggish
stubborn eager to please easy to manage disobedient happy sad angry
loving aloof friendly secure easily frightened bold cautious whining generous
generous jealous cruel aggressive affectionate relates easily to adults
relates poorly to adults attached to certain toys/objects to point of not being able to leave at home.

Have there been noticeable changes in behavior or personality at any time in his/her life? _____

_____

_____

Child/adolescent's life in general: very happy happy average unhappy very unhappy

Child/adolescent's life in past 6 months: very happy happy average unhappy very unhappy

What is your child/adolescent's greatest fear? _____

What is your child/adolescent's greatest hope? _____

Please describe in detail the reason for having this child seen professionally. (Indicate the age/when the problem began, **w**hat seems to make the problem better or worse, **d**escribe feelings and moods observed, and what ways the problem interferes with the life of the child or family?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____