

Child/Adolescent Intake Form

Name: _____

Date: _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

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

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

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

- | | | | | |
|--|--------------------------------------|--|--|-----------------------------------|
| <input type="checkbox"/> Handling everyday tasks | <input type="checkbox"/> Self esteem | <input type="checkbox"/> Relationships | <input type="checkbox"/> Hygiene | <input type="checkbox"/> Health |
| <input type="checkbox"/> Recreational activities | <input type="checkbox"/> Work/School | <input type="checkbox"/> Housing | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Finances |

Yes No Has your child ever had thoughts, made statements, or attempted to hurt him/herself? If yes, please describe: _____

Yes No Has your child ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

Yes No Has your child recently been physically hurt or threatened by someone else? If yes, please describe: _____

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

Therapist Notes:
Init: _____

Name: _____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

Therapist Notes:
Init: _____

SCHOOL INFORMATION

Current grade/placement: _____

- | | | | | |
|------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| This year's school grades: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Past school grades: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| This year's school behavior: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Past school behavior: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

Has your child had any of the following difficulties at school?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Suspension | <input type="checkbox"/> Incomplete homework | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Referrals or detentions |
| <input type="checkbox"/> Poor grades | <input type="checkbox"/> Teased or picked on | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Attendance problems |
| <input type="checkbox"/> Gang influence | | | |

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

Yes No Has your child ever repeated or skipped a grade? If yes, which one(s)? _____

Yes No Has your child ever received Special Education services? If yes, please describe services received and reason for services: _____

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

Therapist Notes:
Init: _____

Name: _____

SUBSTANCE USE HISTORY (for ages 12 and older or if applicable)

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

Yes No Has your child had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

Yes No Has your child ever had problems with work, relationships, health, the law, etc. due to his/her substance use? If yes, please describe: _____

Therapist Notes:
Init: _____

MEDICAL INFORMATION

Date of last physical exam: _____

Has your child experienced any of the following medical conditions during his/her lifetime?

- | | | | |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Surgery | <input type="checkbox"/> Serious accident | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Abortion | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Other: _____ | | | |

Please list any CURRENT health concerns: _____

Current prescription medications: None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: None
If yes, please list: _____

Therapist Notes:
Init: _____

