Child/Adolescent Intake

Date: ___________________

Name: ____ DOB: ________________________

Address: ______________________________City _____________ State ___________ Zip _____________________

Home Phone: _________________________ Cell/Other: ____________________

Sex ☐ Male ☐ Female Age: ________________

Grade (if this is summer, please indicate what grade you will be entering) ______________

School attending ____

Race/Ethnicity

☐ Caucasian ☐ Native American ☐ Multiracial

____

☐ African American ☐ Asia ☐ Latin or Spanish ☐ Other

____

Parent or Guardian living with child/adolescent

Name: _____________________________________ Relationship __________________________

Employer/Address:____

Occupation: ____

Work Phone: ________________ Cell/other: ___________________ Email: ________________________________

Spouse/Partner:____ Relationship __________________________

Employer/Address:____

Occupation: _____________________________Work Phone: ________________ Cell/other: ___________________

Siblings (include biological, adopted, foster, step, etc.)

Name	Sex	Age	Type (bio,step,etc.)	Custody?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Is there any other person living in your household other than parents or siblings? Yes No

If yes, please give name(s) and relationship to you:

____

Is patient adopted? Yes No If yes, at what age? ______________________

Are biological parents divorced or separated? Yes No *If yes, for how long* __________________________

Do parents share joint custody? Yes No *Please provide court documentation*

Person to contact in case of emergency ______________________ Phone Number ______________________

COUNSELING HISTORY OF CHILD/ADOLESCENT

Prior counseling experience:

From: ______________ To: ________________ With Whom? ______________________

How were you referred to me? ____

Is there any history of mental health issues in family? (if yes, please describe) ____________________

____

Basic Health ☐ Good ☐ Fair ☐ Poor Date of last exam? ______________________

Physician's Name: ________________________ Phone: ____________________________

Is child/adolescent taking any prescription medication at this time? ☐ Yes ☐ No

If yes, what? ____

Is child/adolescent taking any over the counter medication at this time? ☐ Yes ☐ No

If yes, what? ____

Current reason for seeking counseling

Are there any physical, emotional, or mental issues now or in the past that I need to be aware of ? Yes No

If yes, what? ____

Has child/adolescent ever been hospitalized? Yes No

If yes, for what and when ____

Briefly describe the problem for which you wish your child/adolescent to have counseling:

____

____

____

The thing that concerns me most right now is: ______________________________

____

____

____

Counseling would be successful if: ______________________________________

____

I understand that suicidal threats, homicidal threats or child abuse will be reported.
I understand that the parent must facilitate the ability for child/adolescent to trust the therapist and will respect confidentiality when appropriate.

Child/Adolescent Signature : ____

Parent (s) Signature : ______________________________ ______________________________

Print names : ______________________________ ______________________________

Initial Service Plan

Please check any of the reasons listed below which resulted in your coming in today:

- ☐ Depression or Anxiety
- ☐ Alcohol or other drug abuse
- ☐ Communication Difficulties
- ☐ Harm to self or others
- ☐ Abuse (physical/verbal/sexual)
- ☐ Sexual Orientation Questions
- ☐ Child Adjustment/Parent Conflict
- ☐ Divorce
- ☐ Adoption
- ☐ ______________________________
- ☐ Difficulty with loss or death
- ☐ School adjustment problems
  - ☐ School learning difficulties
- ☐ Low Self Esteem/social withdraw/motivation
- ☐ General Defiance
- ☐ Staying Focused/Task Completion
- ☐ Eating Disorder/Obesity
- ☐ Individual Counseling
- ☐ Family Counseling
- ☐ ______________________________

What event happened which made you think "I am (we are) calling a therapist?" ______________________________

____

____

Modality – who would you like to see participate in counseling?:

____

____

____

What behaviors would you like to change? ____

____

____

Patient's strengths and interests: ____

____

____

Patient Signature ______________________________ Date ______________________

Parent/Guardian Signature______________________________ Date ______________________

Therapist Signature______________________________ Date ______________________