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Child & Adolescent Intake

Person Completing Form: _____ Date: _____

Your relationship to this child: _____

Are you this child's legal guardian? Yes ☐ No ☐
If no, please explain: _____

Name of Child: _____

What does this child like to be called? _____ Gender: Female ☐ Male ☐

Date of Birth: _____ Age: ____ Child's Address: _____

_____

Telephone: _____ School: _____ Grade: _____

School Address: _____ School Telephone : _____

_____

Mother's Name: _____
Biological __ , adopted ___, step ___, foster ___, other _____

Address: Same as above ☐
If different: _____
_____
_____

Father's Name: _____
Biological __ , adopted ___, step ___, foster ___, other _____

Address: Same as above ☐
If different: _____
_____
_____

Contact Information OK to contact?

Telephone: (H) _____ / _____ - _____ ☐
(W) _____ / _____ - _____ ☐
(C) _____ / _____ - _____ ☐

E-Mail: _____ ☐

Contact Information OK to contact?

Telephone: (H) ____ / _____ - _____ ☐
(W) ____ / _____ - _____ ☐
(C) ____ / _____ - _____ ☐

E-Mail: _____ ☐

With whom does this child live? _____

Siblings

Please list all brothers and sisters of this child:

Name of Sibling	*Age*	*Brother or Sister?*	*Living at home?*

Medical Information

Name of Pediatrician: _____ Telephone: _____

Address: _____

Are there other health professionals involved with this child? Yes ☐ No ☐

→ If yes, please provide their names, specialties, contact information, and reasons why this child is seeing them.

Health Professional #1
Health Professional #2
Health Professional #3
Health Professional #4

Please list any medications this child is taking and for what reason: _____

_____

Please list any serious illnesses or operations/surgeries that this child has had or been through: _____

_____

_____

Has this child ever sustained a head injury, lost consciousness, had a concussion and/or been in a coma? If yes, please explain by including the incident, age, and outcome. _____

_____
_____
_____

Birth and Development

Were there any complications that occurred during the pregnancy or birth of this child? No ____ Yes _____ If yes, please explain:

Did this child experience any developmental delays; i.e., crawling, walking, speaking, motor movement, etc.?
No _____ Yes _____ Not Sure _____ . If yes or not sure, please explain:

Mental Health History

Has this child ever been under the care of a mental health professional; i.e., psychiatrist, psychologist, social worker, counselor, etc. ? No _____ Yes _____

If yes, please explain: _____
_____
_____
_____
_____

Has this child ever had a psychiatric or psychological evaluation? No _____ Yes _____

If yes, please provide the following information:

Who conducted the evaluation? _____

When? _____

For what reason? _____

What was the outcome of the evaluation? _____
_____
_____

Do you have a copy of the evaluation/report? Yes _____ No _____

Reason for Referral

Were you recommended to seek help for this child from any of the following?

	Yes	No
Teacher/School/Educational Facility:	____	____
Pediatrician/Medical Professional:	____	____

What type of service(s) are you seeking for this child?

Educational/Behavioral Evaluation ◯

Specifically:

Gifted Testing ___
Learning Disability ___
Attention Deficit/Hyperactivity Disorder ___
Other _____

Counseling/Therapy ◯

For: _____
_____
_____
_____
_____

Please refer to page 5 to complete the Typical Problems of Children and Adolescents Form.

Additional Information/Comments:

To the best of my knowledge, the information completed on this intake is accurate. I give my consent for you to communicate with this child, this child's doctors and other health professionals for the purpose of coordinating professional services. I understand that I may withdraw this consent by written notice to you at any time.

Signature of Parent or Guardian _____ Date _____

Typical Problems of Children and Adolescents Form

The following list includes typical problems of children at home and/or at school. Please check any of the following that apply to this child:

Behavior	**Currently exhibits** *Indicate in each box how long this has been occurring.*	**Exhibited in the past but NOT currently** *Indicate at what age or how long ago this occurred.*
Anxiety		
Fears/Phobias		
Inattentiveness		
Disobedience		
Academic Difficulty		
Aggression		
Depression		
Conflicts with Peers		
Conflicts with Teachers		
Sadness/Crying		
Low Concentration		
Drug Use		
Legal Conflicts		
Low Motivation		
Distractible		
Low Frustration Tolerance		
Bowel/Bladder Problems		
Under/Overeating		
Fire Setting		
Isolation/Withdrawal		
Sleep Difficulties		

Attention Seeking		
Lying/Cheating		
Speech Difficulties		
Temper Tantrums		
Hyperactivity		
Restlessness		
Running Away		
Accident Prone		
Imaginary Playmates		
Hears or Sees Things that are Not There		
Finger/Foot Tapping		
Repetitive Motor Movements; i.e., rocking, spinning, pacing, talking to one self, other self-stimulatory behavior(s)		
Interrupts Others		
Self-Injurious Behavior(s)		
Inappropriate Sexual Behavior		