

Child/Adolescent Intake

Name _____ **Date** _____

Date of Birth _____/_____/_____ Age _____

What problem(s) have led you and your family to seek help at this time?

School

Grade _____

Do you enjoy school? Y N

Describe any academic problems you have experienced in the past or currently:

List any problems or conflicts you have had at school apart from academics:

Social

Do you make friends easily? Y N

How many close friends do you have? _____

How many acquaintances? _____

How would you describe these friendships:

Clubs/ organizations

Hobbies

Experience with mental health professionals

Have you received therapy in the past? Yes No

Whom have you seen?

Individual therapy _____ Group therapy _____

Quality of experience with therapist: (rate by circling a number)

(Negative) 1 2 3 4 5 (Positive)

Have you been in the care of a psychiatrist? Yes No

Whom have you seen?

Quality of experience with psychiatrist: (rate by circling a number)

(Negative) 1 2 3 4 5 (Positive)

Do you experience or have diagnosis of?

Depression _____ Anxiety _____ ADHD _____ Bipolar Disorder _____ Suicidal

Ideation _____

Other _____

Medications used for psychiatric problems:

Other Health Information

This information is important for understanding your own personal health challenges.

Please **check** those that apply.

Heart disease ____ High blood pressure ____ Stroke ____ Diabetes ____
Thyroid disease (circle one) Hypothyroidism (low) Hyperthyroidism (high)
Brain disorders: Seizures ____ Tumors ____ Infection ____ Injury ____
Lung disease ____ What kind? _____
Kidney problems ____ Bladder problems ____ Liver disease ____
Indigestion/gastric reflux ____ Constipation ____ Inflammatory GI disease ____
Cancer ____ What part of body affected? _____
Arthritis ____ Lower back pain ____ Joint pain ____ Migraine ____ Tension
headaches ____ Other chronic pain ____
What part of the body? _____

Surgeries (please list)

Childhood illnesses (such as middle ear infections, measles)
