CHILD AND ADOLESCENT INTAKE FORM
-- CONFIDENTIAL --

For sole use of Aude Castagna, LMFT 77410

BACKGROUND INFORMATION Date _____

Child's Name _____ Date of Birth _____ Age _____

Child lives with (✓ one): both biological parents _____ mother _____ father _____

mother & stepfather _____ father & stepmother _____ other _____

If parents are divorced, describe custody arrangements: _____

_____

Child's Address/City/St/Zip _____

_____ Child's Home Phone _____

Emergency Contact Person (other than parent)_____ Phone Number _____

INFORMATION ABOUT CHILD'S MOTHER

Mother's Name _____ Age _____

Employer _____ Occupation _____ Hrs/wk _____

Can you be contacted at work by phone? Yes No Work phone _____ ext _____

Describe any physical problems you have that require medication or physical care? _____

_____

INFORMATION ABOUT CHILD'S FATHER

Father's Name _____ Age _____ Race _____

Employer _____ Occupation _____ Hrs/wk _____

Can you be contacted at work by phone? Yes No Work phone _____ ext _____

Describe any physical problems you have that require medication or physical care? _____

_____

FAMILY MEMBERS now living in the household.

Name	Relationship to Child	Age	Highest School Grade Completed	Occupation

WHAT BRINGS YOU TO COUNSELING TODAY? If possible, list questions for which answers are sought: ___

_____

_____

_____

Problem Areas: In the following list, place a check mark (✓) next to each item which identifies an area of concern to you. Place 2 check marks (✓✓) by those items which are most important. (You may add written comments after areas checked.)

_____	Addiction	_____	Self-harming
_____	Anger / Temper	_____	Sexual Concerns
_____	Anxiety	_____	Stealing/lying
_____	Body Image	_____	Tantrums
_____	Bullying	_____	Thoughts of Suicide
_____	Depression	_____	Thoughts of Suicide
_____	Education	_____	Unhappy most of the time
_____	Family Problems	_____	Use of Alcohol/drugs
_____	Fearfulness	_____	Others
_____	Frequent Illness		
_____	Impulse control		
_____	Isolation		
_____	Marital Problems	_____	
_____	Mood Swings	_____	
_____	Problems with Peers	_____	
_____	Running away		

___

MEDICAL HISTORY

List child's serious sickness, operations, and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:

_____

_____

Have there been any previous psychological, psychiatric, neurological, or EEG evaluations? Yes No

When did your child last have a physical examination? _____

Physician's Name _____ Phone _____

PSYCHOLOGICAL HISTORY

Has your child ever received mental health treatment before? When and for how long? _____

Name of last psychiatrist _____

Name of last psychotherapist _____

Have s/he ever been hospitalized for mental or emotional problems? ? Yes No

When and why (diagnostic)? _____

Has s/he ever taken any medications for a mental or emotional condition? _____

When and for how long? Prescribed by whom? _____

Have your child ever attempted suicide? When ? How ? _____

Is s/he currently having any suicidal thoughts? _____

ACADEMIC / SCHOOL INFORMATION

School Name _____ Grade _____ Teacher _____

List previous schools attended _____

Has child ever repeated a grade? Yes No If so, when? _____

How does your child get along at school? _____

Describe difficulties in learning at school: _____

Have other family members had learning difficulties? _____

Describe what your child likes to do for fun, special interests, hobbies, etc. _____

INSURANCE If planning to use health insurance:

Name of insurance company _____

Policy number _____ Group number _____ Telephone number _____

Signature _____ Date _____