Tiffany Thibodeaux, LPC, NCC, RPT
Professional Counselor for Adults & Adolescents

Adolescent & Child Intake Form

Please fill out this form and bring it to your first appointment

PERSONAL INFORMATION		
Name	Date of Birth	Gender
Address	City/Zip	
School	Grade	
Child's Phone Number		

FAMILY INFORMATION		
Mother's Name	Phone Number ( )	
Father's Name	Phone Number ( )	
Email	Email Appointment Reminders?	Y N
	Text Appointment Reminders?	Y N
Emergency Contact	Emergency Phone ( )	
Who does Child live with?		

How did you hear about Tiffany? _____

_____ Private Pay **_____ Blue Cross Insurance** **_____ Other Insurance**

REQUIRED INSURANCE INFORMATION

Name of Insurance Carrier _____ Member ID #_____

Policyholder's Name _____ Policy holder's DOB _____

Name of Employer _____ Group Number _____

Please note: You are required to verify your benefits before attending your first appointment. Our office will not know your exact benefits & coverage until we receive an explanation of benefits from your insurance company after the first billing.

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School Information	
School Name	Grade
Average Report Card Grades □ Honor Roll □ Average Student □ Failing 1 or more class(es)	
Extra-Curricular Activities/Sports:	

Therapy Information
Describe the reason you are seeking counseling for your child.
How long has this problem been going on?
Have your child experienced any major stressors in the last year? *(ex: death of a loved one, major illness, move of home or school, divorce, trauma, loss of employment, abuse, or major life change?)*
What would you like your child to accomplish in counseling?
List some of your child's strengths and weaknesses.
Conditions that your child has been diagnosed with □ Depression □ Anxiety □ Bipolar □ Gender Dysphoria □ OCD □ Schizophrenia □ ADD/ADHD □ Learning Disability □ Other

Medical Information			
Primary Care Physician		Phone Number	
List any important medical history, chronic ailments, or other health problems.			
Does your child take medication for physical or psychiatric conditions? If yes please list medication below			
Name of Medication	Dosage	Condition Treated	Prescribing Physician
List any psychiatric medications that she/he has taken in the past.			

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Family Information
Explain your child's living arrangements, custody issues, and important people in their lives.
Sibling(s) names and age(s)
Who are the other important people in your child's life that they depend on for emotional support? (include friends, family members, religious organizations, clubs etc.)

Answer the following			
Does your child drink alcohol or use illegal drugs?	□ Yes □ No	Have your child ever been arrested or incarcerated?	□ Yes □ No
Does your child currently have outstanding legal charges or court dates?	□ Yes □ No	Has your child ever attempted suicide?	□ Yes □ No
Is anyone requiring your child to attend counseling?	□ Yes □ No	Has your child ever been physically, emotionally, or sexually abused?	□ Yes □ No

Mental Health History		
Has your child ever received a mental health diagnosis?	□ Yes □ No	Diagnosis Physician Name Year
Have your child ever attended counseling before today?	□ Yes □ No	Therapist name Dates: Outcome: □ Successful □ No Change □ Worse
Does your child currently see a psychiatrist or professional who prescribes medication?	□ Yes □ No	Physician name:
Has your child ever had a psychiatric or psychological evaluation?	□ Yes □ No	Reason Physician Name Year
Has your child ever been hospitalized for a psychiatric condition, drug or alcohol abuse, an eating disorder, self-injurious behaviors, or suicidal ideation?	□ Yes □ No	Reason Name of Facility Date(s)
Do you have any close relatives (parents, siblings, grandparents) who have experienced a mental health condition including depression, anxiety, bi-polar disorder, OCD & Schizophrenia?	□ Yes □ No	List relationship and diagnosis
Do any close relatives (parents, siblings, grandparents) have or have had drug or alcohol abuse problems?	□ Yes □ No	List relationship and substance(s) used

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Parental Concerns Checklist

Please read this list and check all issues that concern you about your child.

☐ Abuse/ Neglect	☐ Grief/loss	☐ Oppositional Behavior
☐ Academic Problems	☐ Hallucinations	☐ Panic Attacks
☐ ADD/ADHD	☐ Harms animals	☐ Parent Child Conflict
☐ Aggressive Behavior	☐ Hates being alone	☐ Peer Conflict
☐ Alcohol/Drug Use	☐ Headaches	☐ Phobias
☐ Anger Problems	☐ Homicidal Thoughts	☐ Poor attention/concentration
☐ Anxious or Nervousness	☐ Hopelessness	☐ Restlessness/on edge
☐ Appetite Problems	☐ Hostile	☐ Risk Taking Behaviors
☐ Binge Eating	☐ Hyperactive	☐ Runs away
☐ Blended Family Issues	☐ Immature for age	☐ Self-centered
☐ Can't Say No	☐ Impulsive	☐ Self-destructive
☐ Behavior at School	☐ Isolation from others	☐ Self-Injury/cutting
☐ Cries Often	☐ Hypersensitive	☐ Separation Issues
☐ Damages Property	☐ Lack of Friends/ Loneliness	☐ Serious illness/injury
☐ Depression	☐ Lack of Motivation	☐ Sexually Acting Out
☐ Difficulty Making Decisions	☐ Legal Problems	☐ Sexual Orientation Issues
☐ Distrustful/Guarded	☐ Loss of interest in activities	☐ Shyness
☐ Domestic Violence in Home	☐ Low Self Esteem	☐ Sleep Problems
☐ Divorce – problems with	☐ Lying or stealing	☐ Social Anxiety
☐ Eating Disorder	☐ Manipulative	☐ Suicidal Thoughts
☐ Experienced Trauma	☐ Major life Change	☐ Suicide Attempts
☐ Fighting	☐ Mean to Others	☐ Tired all of the time
☐ Fire Setting	☐ Memory Problems	☐ Truancy
☐ Fearlessness	☐ Nightmares	☐ Victim of Bullying
☐ Fatigue/low energy	☐ OCD behaviors	☐ Victim of Rape
☐ Flashbacks	☐ Negative thoughts/outlook	☐ Weight Gain/Loss
☐ Gender Issues	☐ Mood Swings	☐ Withdrawn

NOTES: _____

_____

_____

Guardian Signature _____ ***Date*** _____