Child And Adolescent Intake Form

To be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand your child. This statement will be kept confidential to the extent to which state law permits.

BACKGROUND INFORMATION

Child's name _____ Date of Birth_____/_____/_____ Age _____

School attending and grade level (if applicable): _____

Child lives with (check one): both biological parents ____ mother ____ father ____ other _____

If parents are divorced, describe custody arrangements: _____

_____

_____

_____

Child's address _____

_____

Emergency contact person (other than parent) _____

Phone number _____-_____-_____

Custodial parent's contact information:

Phone _____ (Home) _____ (Cell) _____ (Work) _____E-mail:_____

INFORMATION ABOUT CHILD'S MOTHER

Mother's name _____ Age_____ Race _____

Employer _____

Occupation _____

Hrs./wk. _____ Can you be contacted at work by phone? Yes No

Circle the best way to contact you:

Phone: _____/ (Home) _____ (Cell) _____ (Work) _____

E-mail _____

Denomination _____ Church _____ Active? Yes No

INFORMATION ABOUT CHILD'S FATHER

Father's name _____ Age_____

Race _____

Employer _____

Occupation _____

Hrs./wk. _____ Can you be contacted at work by phone? Yes No

Circle the best way to contact:

Phone _____ (Home) _____ (Cell) _____ (Work) _____

E-mail _____

Denomination _____ Church _____ Active? Yes No

Please list others living in custodian parent's home, including names, ages, and relationship to child:

_____

_____

Legal Issues

Is there any legal involvement with your child? Yes _____ No ___ If so, please describe: _____

_____

_____

Please bring copies of any court orders that are related to your child to our next session.

Has the court ordered that your child seek counseling?

Presenting Problem: Describe the issue your child is having.

Briefly state the problem that brought you here:

_____

_____

_____

_____

How long has this situation been in existence?

_____

_____

Problem Areas: From the following list, please prioritize each item that identifies an area of concern to you that you have for your child. For example, the number 1 would be placed by the item that concerns you the most today.

_____Anger _____ Shyness

_____Depression _____ Feels hopeless

_____Grades, academic performance _____ Fidgety, unable to sit still

_____Court trouble, legal issues _____ Daydreams too much

_____ Inability to get along with other children _____ Takes unnecessary risk

_____Bullying—being bullied by other children _____ Blames others for his or her troubles

_____Bullying, threatening other children _____ Takes things that do not belong to him or her

_____Religious/spiritual concerns _____ School grades dropping

_____Developmental issues_____ Distracted easily

_____Fights with other children in school _____ Has trouble with his teacher(s)

How were you referred? _____

_____

What are your reason(s) for seeking therapy? _____

_____

What goals do you have for therapy for your child? _____

_____

Have you sought mental health treatment before for your child? _____ Yes _____ No ___

If so, when and with whom? _____

_____

_____

Current medical doctor/family physician: _____ Phone number: _____

Is your child under medical care for any ailment? Is he or she on any medications? If so, please indicate current medications (type and dosage): _____

_____

_____

Have there been any suicide attempts? (If so, explain) _____

In case of emergency, please notify :

Name: _____ Phone: _____ Relationship: _____

Insurance (The following questions are about the policy holder.)

Policyholder's name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home phone: _____ Cell: _____ Work: _____

Insurance company: _____

Authorization #: _____ Number of sessions authorized: _____ Co-pay: _____

Employer: _____

Job title: _____

Form completed by: _____ Date: _____

Signature: _____