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Child and Adolescent Intake Form

Name of Client: _____Date:_____

Parent or Guardian (if applicable): _____

Address:_____

Home Phone:_____May I leave messages at this number?_____

Work Phone:_____May I leave messages at this number?_____

Cell Phone:_____May I leave messages at this number?_____
*Please note that confidentiality cannot be guaranteed with wireless calls

E-Mail:_____

Birthdate:_____ Age:_____

Grade Completed:_____School:_____

Teacher Name: _____Phone Number: _____

Cultural Heritage:_____Spiritual Practice:_____

Other Issues of Diversity to be Considered: _____

_____

Presenting Problem(s):

_____

_____

_____

_____

When did the problems start?

_____

_____

Any Medical Conditions or Symptoms? If so, please describe:

_____

_____

Physician Name and Number: _____

Psychiatrist Name and Number: _____

Medication(s): _____

In the Event of an Emergency, Please Notify:_____Phone:_____

Family Constellation

	Name of Individual	Date of Birth	Year Married	Year Divorced	Year Deceased
Mother					
Father					
Step-Mother					
Step-Father					
Sibling					
Sibling					
Sibling					
Spouse or Partner					
Other					
Child					
Child					
Child					
Child					

Has your child ever had any previous counseling? If so, where, how long, and did you feel it was helpful?

_____

_____

_____

_____

_____

_____

Additional Intake Information for Children and Adolescents

Developmental History

Please describe your child's mother's pregnancy and delivery:

Please describe your child's early development. Please include any complications like feeding problems, developmental delays, colic, chronic illnesses, etc.

Developmental Milestone	*Age Achieved*
First Smile	
First Rolled Over	
Sat Unassisted	
Began Pointing to Desired Objects	
Weaned From Breast or Bottle	
Began Crawling	
Feeds Self	
Walking	
Running	
First Words	
Full Sentences	
Entered School (includes preschool or daycare)	
Potty Trained	

Please describe any history of illnesses, injuries, or accidents:

Please describe how you feel your child relates to others:

Does your child participate in any extracurricular activities? If so please describe:

Please describe your child's school history. Include information regarding grades, any learning complications, favorite and least favorite subjects, any behavioral difficulties, and/or feedback about your child from his/her school that may be helpful:

Please describe significant events in your family life that may have had an impact on your child (i.e. major moves, changes in school, divorce, loss of a loved one, abuse and/or assault of any kind, legal troubles):

Is there any history of any psychological or developmental disorders in your family (i.e. ADHD, autism, schizophrenia, speech delays)? If so, please describe:

Is there any history of substance abuse in your family?

What are your child's strengths?

Are you aware of your child having any sensory issues? Sensitivity to loud noises, sensitivity to touch, needing to have the tags cut out of his/her clothes, being a picky eater, etc.

Any other information not covered above that you think may be useful in treating your child: