

Child/Adolescent Intake Form

Name: _____

Date: _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

Please check all your child's behaviors and symptoms that you consider problematic:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Visual hallucinations | <input type="checkbox"/> Manipulative behavior |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Withdrawal from people | <input type="checkbox"/> Defiance | <input type="checkbox"/> No/few friends |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Anxiety/worry | <input type="checkbox"/> Aggression/fights | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Boredom | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Poor memory/confusion | <input type="checkbox"/> Fear away from home | <input type="checkbox"/> Frequent arguments | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Sadness/depression | <input type="checkbox"/> Social discomfort | <input type="checkbox"/> Irritability/anger | <input type="checkbox"/> Toileting problems |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Phobias | <input type="checkbox"/> Peer/sibling conflict | <input type="checkbox"/> Fire setting |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Stealing | <input type="checkbox"/> Work/school problems |
| <input type="checkbox"/> Self-harm behaviors | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Destroys property | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Running away | <input type="checkbox"/> Sexual behavior |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Wide mood swings | <input type="checkbox"/> Swearing | <input type="checkbox"/> Computer addiction |
| <input type="checkbox"/> Low self worth | <input type="checkbox"/> Suspicion/paranoia | <input type="checkbox"/> Curfew violations | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Lying | <input type="checkbox"/> Lack of motivation |
| <input type="checkbox"/> Recurring, disturbing memories | | <input type="checkbox"/> Other: _____ | |

Are your child's problems affecting any of the following?

- ☐ Handling everyday tasks ☐ Self esteem ☐ Relationships ☐ Hygiene ☐ Health
☐ Recreational activities ☐ Work/School ☐ Housing ☐ Legal matters ☐ Finances

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt him/herself? If yes,
please describe: _____

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

☐ Yes ☐ No Has your child recently been physically hurt or threatened by someone else? If yes, please describe:

☐ Yes ☐ No Has your child gambled in the past 6 months? If yes, let us know the following

☐ Yes ☐ No Has your child ever felt the need to bet more and more money?

☐ Yes ☐ No Has your child ever had to lie to people about how much your child has gambled?

Therapist Notes:

Init:

Name: _____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Outpatient Counseling			
<input type="checkbox"/>	<input type="checkbox"/>	Medication (mental health)			
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Hospitalization			
<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Treatment			
<input type="checkbox"/>	<input type="checkbox"/>	Self-help/Support Groups			

Therapist Notes:
Init: _____

SCHOOL INFORMATION

Current grade/placement: _____

This year's school grades:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Past school grades:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
This year's school behavior:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Past school behavior:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

Has your child had any of the following difficulties at school?

<input type="checkbox"/> Suspension	<input type="checkbox"/> Incomplete homework	<input type="checkbox"/> Learning problems	<input type="checkbox"/> Referrals or detentions
<input type="checkbox"/> Poor grades	<input type="checkbox"/> Teased or picked on	<input type="checkbox"/> Speech problems	<input type="checkbox"/> Attendance problems
<input type="checkbox"/> Gang influence			

☐ Yes ☐ No Does your child have an after-school provider? If so, who? _____

☐ Yes ☐ No Has your child ever repeated or skipped a grade? If yes, which one(s)? _____

☐ Yes ☐ No Has your child ever received Special Education services? If yes, please describe services received and reason for services: _____

What does your child's teacher(s) say about him/her? _____

Therapist Notes:
Init: _____

Name: _____

SUBSTANCE USE HISTORY (for ages 12 and older or if applicable)

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

☐ Yes ☐ No Has your child had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

☐ Yes ☐ No Has your child ever had problems with work, relationships, health, the law, etc. due to his/her substance use? If yes, please describe: _____

Therapist Notes: _____

Init: _____

MEDICAL INFORMATION

Date of last physical exam: _____

Has your child experienced any of the following medical conditions during his/her lifetime?

- | | | | |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Surgery | <input type="checkbox"/> Serious accident | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Abortion | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Other: _____ | | | |

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: ☐ None

If yes, please list: _____

Therapist Notes: _____

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INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your child's social support network (check all that apply):

☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one? _____)

To which cultural or ethnic group does your child belong? _____

If your child is experiencing any difficulties due to cultural or ethnic issues, please describe: _____

How important are spiritual matters to your child? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much
☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your child's counseling?

Please describe your child's strengths, skills, and talents? _____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _____

Therapist Notes:
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LEGAL INFORMATION

If the parents are separated or divorced, what is the current child custody/visitation arrangement? _____

☐ Yes ☐ No Is your child currently the subject of a custody case?
☐ Yes ☐ No Has your child ever been a ward of the court with SCF/DCFS guardianship?
☐ Yes ☐ No Does your child have any legal offenses on record or pending in the courts?

Therapist Notes:
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