Intake Form

Date_____

Child's Last Name _____ **First Name(s)** _____

☐ Male ☐ Female Date of Birth ___/___/____

Parent/Legal Guardian Name_____

Other Involved Adult: _____ **Relationship:** _____

Will this adult be involved in treatment? _____

Address _____ **City** _____ **State** _____ **Zip** _____

Do I have permission to send mail to this address? Y / N

E-mail Address: _____

Telephone: Home _____ Cell _____ Work _____

Is it acceptable to contact you at home by phone? Y / N By cell phone? Y / N

If none of the above options is acceptable, how may I contact you? _____

How did you hear of me?_____

Who may I thank for referring you? _____

Please check any current general issues or past issues that still affect your child.

- ☐ Anxiety
- ☐ Fears/phobias (type: _____)
- ☐ Sexual problems
- ☐ Separation/divorce
- ☐ Drug/alcohol use
- ☐ Anger
- ☐ Addiction
- ☐ Religious matters
- ☐ Health problems
- ☐ Thought patterns (type: _____)
- ☐ Death of someone close
  - ☐ recently (when:_____)
  - ☐ in the past
- ☐ Sexual assault/rape
  - ☐ recently (when:_____)
  - ☐ in the past
- ☐ Childhood abuse
- ☐ Sexual identity issues
- ☐ Pornography
- ☐ Other _____
- ☐ Depression
- ☐ Eating disorders
- ☐ Suicidal thoughts
- ☐ Finances
- ☐ Career Choices
- ☐ Self-Control
- ☐ Insomnia
- ☐ Work/Stress
- ☐ Cutting/Self-harm
- ☐ Pregnancy Issues
- ☐ Relationship Concerns
  - ☐ family
  - ☐ friend
  - ☐ parent
  - ☐ significant other
  - ☐ roommate
- ☐ other: _____
- ☐ Academic Issues
- ☐ Conduct problems

Child's Current Functioning

Please describe the particular issue(s) that have brought you to counseling. Briefly include any relevant information on when these problems began, how often they occur, and/or the severity of these issues.

Who provides your child with social and emotional support? How do you describe their network of friends?

Please tell me about your child's interests.

Please tell me about your child's strengths.

What do you hope therapy will accomplish?

Has your child previously seen a therapist? ____ Name _____

When? _____ For what issue(s)? _____

_____

What was effective about that treatment?

What was ineffective about that treatment?

Education

Current School _____ Current Grade _____

Previous Schools _____

Please describe how your child experiences school. What are the challenges? Who provides support? Does your child have educational accommodations (504, IEP)?

Family of Origin

Has this child always lived with you? ___ If no, what were the circumstances of the change?

Are there other children in the home? Have there been other children in the home? Please describe your child's interaction with them.

Who are the adults who have been a part of your child's life within the family structure? Who have not been involved or have ceased being involved or are newly involved in their life? (biological parent, step-parent, care-giving relative) What were the circumstances?

Describe yourself as parent/guardian:

Name _____
Occupation _____
Education _____
General health _____

Other primary caregiver:
Name _____
Occupation _____
Education _____
General health _____

How would you describe your family's involvement in the community? Where do you find support? How would you describe your connections to friends and extended family?

Please mark any issues that are present in your family, including extended family:

Issue	**Family member(s)**
_____ Mental illness (incl. depression and anxiety)	_____
_____ Birth defects	_____
_____ Chronic illness	_____
_____ Hereditary illness	_____
_____ Alcoholism	_____
_____ Drug abuse	_____
_____ Physical abuse	_____
_____ Sexual abuse	_____
_____ Behavior problems	_____

Medical Health / History

Is your child currently under medical care? If yes, please explain/describe:

Does your child have health concerns that are untreated at this time? If yes, please describe:

Name of primary physician: _____ Phone number: _____

Address:

Medical Health / History (cont.)

Please list current medications (including herbal and over-the-counter).

Name of medication	Start Date	Dosage	Comments

List psychiatric/mental health medications your child has taken in the past, including herbal substances:

_____

_____

Please list any time(s) in which your child received care from a psychiatrist, psychologist, or counselor:

Clinician **Location** **Date** **Nature of problem/ Diagnosis**

_____

_____

Has your child ever been hospitalized for physical or mental health reasons? _____
Briefly describe including dates.

Is your child, or have they ever been, suicidal? Briefly note dates and whether they have attempted suicide.

Has your child ever experienced a traumatic event? Please describe.

Specific Symptoms

Please rate your understanding of your child's experience of the following specific symptoms using the key below. It is a lengthy list, but it can help you and your therapist to identify specific problems.

Never = 0; Seldom =1; Often = 2; Always = 3

_____ Difficulty concentrating
_____ Vision or hearing problems
_____ Stealing
_____ Feeling helpless
_____ Eating binges
_____ Feeling hopeless
_____ Lying to others
_____ Sexual preoccupation
_____ Feelings of worthlessness
_____ Injuring self *List:* _____
_____ Memory loss/blackout
_____ Crying
_____ Weight gain/loss
_____ Anger
_____ Worrying
_____ Feeling afraid
_____ Withdrawing socially
_____ Feelings of self-doubt
_____ Nervous around others
_____ Seizures
_____ Missing classes
_____ Lack of energy
_____ Feeling uptight
_____ Lack of interest
_____ Guilt feelings
_____ Feeling out of control
_____ Suicidal thoughts

_____ Irritability
_____ Racing thoughts
_____ Decreased need for sleep
_____ Impulsivity
_____ Difficulty sleeping

_____ Shortness of breath
_____ Trembling/shaking
_____ Nausea
_____ Chest pain
_____ Panic attacks
_____ Dizziness/Faintness
_____ Sweating
_____ Numbness
_____ Fear of dying
_____ Palpitations
_____ Sensation of choking
_____ Hot flashes/chills
_____ Fear of "going crazy"

_____ Muscle tension/ache
_____ Frequent urination
_____ Easily startled
_____ Restlessness
_____ Trouble swallowing
_____ Dry mouth
_____ Feeling "on edge"

_____ Recurrent dreams
_____ Hallucinations
_____ Physiological reaction to trauma reminders
_____ Difficulty recalling aspects of past trauma
_____ Intrusive recollections
_____ Difficulty feeling emotions
_____ Avoidance of certain memories
_____ Distress to trauma reminders
_____ Flashbacks
_____ Lack of sense of future

_____ Physical symptoms *(e.g., headaches, digestive) Have you seen a health care provider for these?* _____

_____ Sexual functioning problems *Have you seen a health care provider for these?* _____

_____ Other: _____ _____ Other: _____

Emergency Notification

In case of emergency, notify:

Name: _____

Address: _____
_____
_____

Cell Phone: ( ) _____
Home Phone: ( ) _____

Relationship: _____

OR

Name: _____

Address: _____
_____
_____

Cell Phone: ( ) _____
Home Phone: ( ) _____

Relationship: _____

_____ / _____ _____
Parent/Guardian's Signature (for clients under 18) Relationship to Client Date

_____ _____
Adolescent's Signature (for clients 13 and over) Date