

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.

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

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Parent/Guardian Initials _____

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

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Impulsivity | |

- | | | |
|--|--|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dizziness/Faintness | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Trembling/shaking | <input type="checkbox"/> Sweating | <input type="checkbox"/> Sensation of choking |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Numbness | <input type="checkbox"/> Hot flashes/chills |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fear of dying | <input type="checkbox"/> Fear of "going crazy" |
| <input type="checkbox"/> Panic attacks | | |

- | | | |
|--|---|--|
| <input type="checkbox"/> Muscle tension/ache | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Feeling "on edge" |
| <input type="checkbox"/> Easily startled | | |

- | | | |
|--|--|--|
| <input type="checkbox"/> Recurrent dreams | <input type="checkbox"/> Intrusive recollections | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Difficulty feeling emotions | <input type="checkbox"/> Lack of sense of future |
| <input type="checkbox"/> Physiological reaction to trauma reminders | <input type="checkbox"/> Avoidance of certain memories | |
| <input type="checkbox"/> Difficulty recalling aspects of past trauma | <input type="checkbox"/> Distress to trauma reminders | |

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