Child / Adolescent Intake Document

This form has been designed to ask questions about you and your child's history and current symptoms and will provide useful information for your psychological assessment and treatment. While it may be time consuming, please do your best to complete it fully. If you feel uncomfortable completing any sections, feel free to leave them blank.

Basic Information

Name____Date of Birth____________Date__________

Full Address____

____

Home Phone___________________________Cell Phone_______________________E-mail______________

Physical History

What is the name of your child's medical doctor?____

Address: _____________________________________ Phone:_________________________________

Date of your child's last medical examination:____

Did your child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Were there any problems or complications during the pregnancy or at delivery? If so, Please describe them:

Did your child have any delays in reaching developmental milestones? Please estimate when your child gained these skills.

Talking? Walking?

Potty Training?

Has your child experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	Allergies

Eye/ear problems Meningitis Hearing problems Loss of consciousness

Other

Is your child taking any medication?___________If yes, what kind?____________________________________

Reason for medication_______________________________For how long?________________________________

Has your child ever been hospitalized for a physical illness?____Describe________________________________

____

Has your child ever been hospitalized for a mental illness?____Describe_________________________________

____

Any recent major illnesses or surgeries?____

Any recurrent or chronic conditions?____

Does your child smoke?________Does your child take drugs?________If yes, what kind?________________

Does your child drink?________How much?____

Any Previous Therapy/Counseling?______If yes, describe, when, where, how long, what for___________

____

Any Previous Psychological testing?______If yes, describe, restuls _______________________________

____

Note: If your child has been previously evaluated, please provide a copy of the report.

Family History:

The name of the child's biological parents:

Mother:_____________________________________ Father:_____________________________________

Who has legal guardianship of your child?

Who does your child currently live with?

Names	**Ages**	**Relationship to child**

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Helping individuals reach their full potential

Who are significant people in your child's life that do NOT life with him/her?

Names **Ages** **Relationship to child**

Has anyone in your family ever been diagnosed with a mental health disorder or has experienced mental health challenges? If yes, what relation are they to your child and what was there identified mental health diagnosis?

Education History:

What school does your child attend?

Address:____

Phone:______________________________ Teachers Name:______________________________

Current Grade:______________________

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

Other schools attended (including Pre-school)

Has your child ever repeated a grade? If so which one(s)

Has your child ever received special education services?

If yes, please provide a copy of your child's most recent IEP or 504 Plan

Has your child experienced any of the following problems at School?

Fighting drug/alcohol detention few friends

Suspension learning disabilities poor attendance poor grades

Gang influence incomplete homework behavior problems bullying

Other

Psychological History

Has your child ever had difficulty with the following: (If so, please specify when)
Depressed mood, feelings of helplessness or worthlessness, and decreased motivation

Stress, anxiety, or tension that was beyond what would be expected for a given event

Distressing physical sensations such as shortness of breath, racing heart, dizziness, etc

Obsessive thoughts or images that s/he could not ignore

Repetitive behaviors or rituals that s/he felt compelled to complete

Distressing memories, flashbacks, or dreams in response to a traumatic event including nightmares

Over the last two weeks, how often have you noticed your child may have been bothered by any of the following problems?

	Not at all	Several days	More than ½ the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down or hopeless or sad				
Feeling tired or having little energy				
Poor appetite or overeating				
Difficulty concentrating				
Feeling irritable				
Poor sleeping or excessive sleeping				

If you checked off any problems, how difficult were these problems regarding your child's ability to complete daily tasks like schoolwork, chores, and getting along with others?

Not at all difficult   Somewhat difficult   Very difficult   Extremely difficult

Has there ever been a time when your child was not his/her normal self and…

	Yes	No
They were so hyper they didn't appear themselves?		
They felt so good it led to getting in trouble?		
They slept less than usual but didn't seem to need it?		
They had more energy and completed more activities than usual?		
They were much more irritable than usual?		

They were much more social than usual? For example, calling friends in the middle of the night; chatting with strangers		
They engaged in risky behavior?		
They showed hypersexual behavior?		

If you checked yes to more than one of the above, have several of these ever happened during the same period of time? (If so, please mark which ones above)

How much of a problem did any of these cause your child – like being unable to attend school; having family, money, or legal troubles; getting into arguments or fights?

No problem Minor problem Moderate problem Serious problem

Have any of your blood relatives been diagnosed with bipolar disorder?______________________________

Please answer the questions below using the option on the right that best describes what you may have noticed in your child over the past six months.

	Never	Rarely	Sometimes	Often	Always
How often does s/he have difficulty staying organized?					
How often does s/he have problems remembering things?					
How often does s/he fidget or squirm when required to stay seated?					
How often does s/he make careless mistakes?					
How often does s/he have difficulty paying attention during boring or repetitive tasks?					
How often does s/he misplace items?					
How often is s/he distracted?					
How often does s/he interrupt others who are talking?					
How often does s/he have trouble unwinding after an activity or day?					
How often does s/he have trouble waiting his/her turn?					
How often does s/he appear to “space out”?					

What do you hope to gain from assessment / treatment?

What goals do you have for your child as s/he grows into an adult?

What are areas of strengths for your child?

Do you have any worries or concerns about moving forward with assessment / treatment? If yes, please describe

I understand that it is important to provide accurate information in order to tailor treatment and assessment to meet my child's needs. This information is correct as I have described it.

______________________________________ ______________________

Caregiver Signature Date