Child/ Adolescent (Ages 0-17 years) Intake Form
To be completed by the child's parent/ guardian

Please complete all the information on this form and email before your first visit. It may seem long, but most of the questions only require a check so it will go quickly. Thank you!

Today's Date:

Child's Full Name: _____Date of Birth:_____ Age:_____

What are the reasons for your visit today?
1.
2.
3

If seeking therapy, what are your treatment goals?
1.
2.
3.

Current Symptom Checklist: *Does your child have a history of….*

☐ Academic/ Learning Problems: ☐ Reading ☐ Math ☐ Writing ☐ School Refusal

☐ Bedwetting/ Soiling Problems: ☐ Yes ☐ No

☐ Abuse History: ☐ Physical ☐ Sexual ☐ Verbal ☐ Neglect

☐ Witnessing Domestic Violence/ Abuse? ☐ Yes ☐ No

☐ Experiencing the loss of death of a close loved one? ☐ Yes ☐ No
If yes, please list (who and date):

☐ Experiencing any other traumatic events (i.e., bullying, medical, natural events, school/ community violence)? ☐ Yes ☐ No
If yes, please list (what and date):

☐ Hearing voices no one else hears or seeing things no one else sees? ☐ Yes ☐ No

☐ History of Harm to Self/ Others:

Past Suicidal Thoughts/ Gestures:	☐ Denied	☐ Ideation	☐ Plan	☐ Intent
Current Suicidal Thoughts/ Gestures:	☐ Denied	☐ Ideation	☐ Plan	☐ Intent
Past Homicidal Thoughts/ Gestures:	☐ Denied	☐ Ideation	☐ Plan	☐ Intent
Current Homicidal Thoughts/ Gestures:	☐ Denied	☐ Ideation	☐ Plan	☐ Intent

Past history of self-harm: ☐ Yes ☐ No
Currently engaging in self-harm: ☐ Yes ☐ No
If yes, age of onset, duration, and was medical attention needed:

CURRENT CONCERNS:

Emotional:

- ☐ Irritable or Depressed Mood
- ☐ Panic Attacks
- ☐ Sadness
- ☐ Confusion About Self
- ☐ Easily Startled
- ☐ Loss of Energy
- ☐ Trouble Calming Down
- ☐ Avoids certain items, places, situations, persons
- ☐ Loss of Interest in Activities
- ☐ Loss of Energy
- ☐ Mood Swings
- ☐ Temper Tantrums
- ☐ Trouble Expressing Emotions
- ☐ Overreacts When Faced with a Problem
- ☐ Tearfulness or Frequent Crying Spells
- ☐ Low Self-Esteem
- ☐ Repetitive/ Obsessive Thoughts
- ☐ Anxiety/ Worry/ Fears
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Hides Feelings
- ☐ Other (list):

Physical:

- ☐ Difficulty/ Changes in Sleep
- ☐ Dizziness
- ☐ Other (list):
- ☐ Changes in Appetite or Eating Habits
- ☐ Change in weight
- ☐ Headaches
- ☐ Stomachaches

Behavioral:

- ☐ Concentration/ Focus Problems
- ☐ Doesn't Complete Tasks to Completion
- ☐ Daydreams/ Zones Out
- ☐ Impulsive
- ☐ Self-Hygiene Habits
- ☐ Trouble with Transitions
- ☐ Physical Aggression
- ☐ Cruelty to Animals
- ☐ Truancy (home or school)
- ☐ Argues with Adults
- ☐ Substance Use
- ☐ Purging/ Restricting Food
- ☐ Other (list):
- ☐ Avoids Tasks that Are Difficult or Boring
- ☐ Trouble Remaining Seated
- ☐ Always "On the Go"
- ☐ Hyper-focuses
- ☐ Strict Routines
- ☐ Repetitive Body Movements
- ☐ Lying
- ☐ Defiance/ Noncompliance
- ☐ Sexual Behaviors
- ☐ Trouble Accepting Responsibility/ No
- ☐ Legal Problems
- ☐ Calorie Counting
- ☐ Loses Items
- ☐ Easily Distracted
- ☐ Restless or Fidgety
- ☐ Makes Careless Mistakes
- ☐ Limited/ Specific Interests
- ☐ Verbal Aggression
- ☐ Stealing
- ☐ Tantrums
- ☐ Blames Others
- ☐ Fire-setting
- ☐ Hair-picking
- ☐ Excessive Exercise

Social:

- ☐ Family Conflicts
- ☐ Communication/ Respect with Adults
- ☐ Poor Eye Contact
- ☐ Respecting Personal Space
- ☐ Clingy/ Trouble Separating
- ☐ Social Media/ Online Interactions
- ☐ Overly Stimulated in Play
- ☐ Other (list):
- ☐ Negative Peer Relationships
- ☐ Making Friends
- ☐ Reading Social Cues
- ☐ Sportsmanship
- ☐ Attachment to Others
- ☐ Bullies Others
- ☐ Withholds Affection
- ☐ Isolates Self / Withdraws from Others
- ☐ Keeping Friends
- ☐ Conversations
- ☐ Sharing
- ☐ Joining In
- ☐ History of Being Bullied
- ☐ Overly Energetic in Play

DEVELOPMENTAL HISTORY: ☐ Developmental History Unknown

Were there any medical problems during pregnancy? ☐ Yes ☐ No
If so, please describe:

Was your child born on time? ☐ Yes ☐ No If not, at how many weeks gestation? _____

Child's birth weight: _____ (lbs, oz)

Was your child born: ☐ Naturally ☐ via C-section

Were there any medical problems during labor or delivery? ☐ Yes ☐ No
If so, please describe:

Did your child spend any time in the Neonatal ICU? ☐ Yes ☐ No

Was your child exposed to medications, toxins, alcohol or cigarettes before birth? ☐ Yes ☐ No
If so, please list:

Were there any problems in the first year of life? ☐ Yes ☐ No
If so, please describe:

Developmental milestones (i.e., walking, talking, toilet training) achieved: ☐ early ☐ on time ☐ delayed

Please describe what your child was like during from 0-4 years of life with respect to the following attributes:

Ability to soothe him/her self when upset:

Showing initiative and curiosity:

Seemed to be dependent on external rewards to achieve behaviors desired by parents:

Activity level:

History of speech therapy? ☐ Yes ☐ No
If so, when/ where?

History of occupational therapy? ☐ Yes ☐ No
If so, when/ where?

Does your child exhibit any sensory difficulties? ☐ Yes ☐ No
If so, please describe (loud sounds, textures, smells, crowds, lights, etc.):

MEDICAL HISTORY
Current Primary Care Physician or Practice: Date of last physical:

How is your child's general health?

History of:

☐ Physical Disabilities	☐ Asthma	☐ Head Injury	☐ Surgeries
☐ Stitches	☐ Broken Bones	☐ Burns	☐ Overnight Hospitalizations
☐ Frequent Ear Infections	☐ Seizures	☐ Vision Problems	☐ Loss of Consciousness
☐ Chronic Illness	☐ Severe Illness	☐ Hearing Difficulties	☐ Constipation/ GI Problems
☐ Feeding or Eating Issues			
☐ Allergies (List):			

Previous medication trials? ☐ Yes ☐ No

Note: If uncertain, this information may be obtained from your pharmacy where prescriptions were filled. You may skip this section if you bring a printout of meds generated by your pharmacy at the time of the initial appointment

Name of Medication	**Maximum Dose**	**Dates Prescribed (from-to)**	**Reason for Stopping**

Current medication? ☐ Yes ☐ No

Please list any medication(s) and the dosage(s) your child is ***currently*** taking, including any over-the-counter medications (*daily vitamins, hormones, herbal supplements, allergy medications and/or frequent dosages of acetaminophens/ ibuprofen*):

You may skip this section if you bring a printout of meds generated by your pharmacy at the time of the initial appointment

Name of Medication	**Maximum Dose**	**Date Prescribed**	**By Whom**
1.			
2.			
3.			
4.			

ACADEMIC HISTORY

Please list all schools attended and for which ages/ grades.

Preschool/ Daycare:

Elementary:

Middle School:

High School:

Current School: Current Grade:
Type of School: ☐ Public ☐ Private ☐ Charter ☐ Homeschool

Current Grades: Recent change in grades? ☐ Yes ☐ No

Skipped or Repeated Grade(s)? ☐ Yes ☐ No *If yes, please explain:*

Has your child ever had an IEP (Individualized Education Plan)? ☐ Yes ☐ No
If so, starting in which grade? In which category: ☐ OHI ☐ BED ☐ AU

Has your child ever had a 504 Plan ☐ Yes ☐ No
If so, starting in which grade?

Has your child had educational testing to identify a learning problem or giftedness? ☐ Yes ☐ No
If so, please provide copies of any reports/ evaluation at your appointment.

Are you concerned about your child's academic performance? If so, please explain:

Please list any other notable school problems (i.e., attention, focus, avoidance/ school refusal, behavior, etc.):

FAMILY HISTORY

Caretaker 1—Name: D.O.B.: Age: Relationship to Youth:
Education level: Occupation:

Caretaker 2—Name: D.O.B.: Age: Relationship to Youth:
Education level: Occupation:

Child is: ☐ Biological ☐ Adopted ☐ Foster ☐ Other _____

Biological Parents are: ☐ Married ☐ Divorced* ☐ Separated* ☐ Never Married ☐ Other _____.

Type of Legal Custody: ☐ Sole* ☐ Joint ☐ Other _____
Type of Physical Custody: ☐ Sole ☐ Joint ☐ Other _____
* *Please provide current separation agreement or court order to verify legal custody*

Do you currently have any pending custody matters? ☐ Yes ☐ No

Has Child Protective Services ever been involved or has there been an abuse report filed against any of the child's care takers? ☐ Yes ☐ No
If yes, please explain (When, what, who was involved, what state, what was the finding):

Who does the child currently live with?:

Name	Age	Relationship to Child

How do family members get along?

Marital/ Couple's Relationship:	☐ Positive	☐ Negative	☐ Variable	☐ N/A
Co-parent's Relationship:	☐ Positive	☐ Negative	☐ Variable	☐ N/A
Mother with Child:	☐ Positive	☐ Negative	☐ Variable	☐ N/A
Father with Child:	☐ Positive	☐ Negative	☐ Variable	☐ N/A
Client & Sibling Relationship:	☐ Positive	☐ Negative	☐ Variable	☐ N/A
Extended Family Relationships:	☐ Positive	☐ Negative	☐ Variable	☐ N/A

Who is charge of discipline at home?

Do caregivers agree on discipline?

What types of discipline methods are used?

Please explain any current familial stressors:

MENTAL HEALTH HISTORY

Previous diagnosis(es)? ☐ Yes ☐ No

If yes, specify:

Previous history of therapy/ counseling? ☐ Yes ☐ No
If yes, specify name of therapist/agency, dates of treatment, type of therapy if you know it (CBT, DBT, etc.:

Previous history of psychological evaluation? ☐ Yes ☐ No
If yes, specify date(s) and evaluator or agency. Please provide copies of any reports or evaluations if you have them.

Previous history of psychiatric hospitalizations? ☐ Yes ☐ No
If yes, specify hospital name, dates, and length of stay:

Previous psychiatric hospitalizations for family members? ☐ Yes ☐ No
If yes, please specify:

Any family members with history of mental health disorders? ☐ Yes ☐ No
If yes, specify:

Any family members with history of suicide? ☐ Yes ☐ No
If yes, specify:

SOCIAL INTERACTIONS/ FRIENDSHIPS/ RECREATION
Does your child have difficulty relating or playing with others: ☐ Yes ☐ No
If yes, describe:

Your child gets along better with peers who are (check all that apply):
☐ Younger ☐ Same Age ☐Older ☐Adults ☐ No preference

What activities or hobbies does your child enjoy?

CULTURAL BELIEFS AND PRACTICES
Does your family identify with a specific cultural or ethnic group? ☐ Yes ☐ No
If yes, specify:

Does your family belong to a particular religion or spiritual group? ☐ Yes ☐ No
If yes, specify:

If your family does not belong to a group, does your family have any spiritual beliefs or life philosophy that is important to you? ☐ Yes ☐ No
If yes, specify:

Are there any other cultural/religious considerations/ needs that we should be aware of?
☐ Yes ☐ No *If yes, specify:*

What are your child's strengths?

Please share any other information that you believe may help my ability to provide effective care for your child.

Please describe any other concerns you have about your child's treatment below.

Your child's comfort is very important and some material is better discussed with them not present. Is there anything in the above information that you do not want your child to know?

Please list below any other specific questions you might have:

Person who completed this form:
Relationship to child: