Child and Adolescent Intake Form

Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Gender: _____

Birthplace: _____ Race: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Name: _____ Policy ID: _____

Name of parent(s)/guardian(s) who have legal custody of child (All legal parent(s)/guardian(s) MUST provide written consent for services):

_____

** Address if parent/guardian lives in another residence:*
Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a voicemail? *YES* ☐ *NO* ☐
Is it ok to send you something in the mail? *YES* ☐ *NO* ☐

How were you introduced to me? _____
If you found me online what words did you search to find me?

_____

How Have We Come to Meet?

What are the 3 biggest concerns you have for your child right now? How long have each been going one? Put them in order of importance:

1. _____
2. _____
3. _____

What do you think your child would say their biggest concern(s) is/are?

_____

_____

_____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____

_____

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Have you or your child(ren) had therapy in the past? If so, please provide treatment providers names, dates of service, what your child was seen for, and results.

Change is Coming…

What are your expectations from therapy and the therapist?

If you had a crystal ball and were able to look into the future you will say therapy has been worth it because (list concrete changes you would like to see):

What other things would you like to see change in your life and your family's life?

Do you foresee any obstacles to achieving your goals/changes?

How long will therapy need to last to achieve the changes/goals you want? Write down a target date:

List 5 strengths about your child, give examples of each:

1.
2.
3.
4.
5.

Medical Background

Has your child ever received psychiatric services before? YES ☐ NO ☐
If yes, how long ago, with whom, for what, and results:

Many parents have opinions on psychiatric medications, what are yours?

_____
_____

Does your child have any allergies (food, environmental, medicinal, animal, etc.)
_____

Any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what?
_____
_____

Is your child presently under a physician's care? If so, for what?
_____
_____

List medications (over the counter & prescribed), nutritional or herbal supplements, alternative treatments (acupuncture, chiropractic, etc.) your child is taking/doing and reasons:
_____
_____

Tell us about the pregnancy of your child (full term, preemie, any complications during pregnancy or at birth, environment and situations during pregnancy and birth).
_____
_____

Tell us about your child's development milestones (delayed, on time, early)
_____
_____

Important Questions I Must Ask

Has your child ever had suicidal ideations? YES ☐ NO ☐
If yes, please explain:
_____
_____

Has your child ever planned to hurt himself/herself? YES ☐ NO ☐
If yes, please explain:
_____
_____

Has your child ever attempted to hurt himself/herself? YES ☐ NO ☐

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If yes, please explain:

_____

_____

Has your child ever felt like he/she wanted to seriously hurt or harm someone else?
If yes, please explain: YES ☐ NO ☐

_____

_____

Do you have weapons in your home or access to weapons? YES ☐ NO ☐
If yes, who has access to them and what are the safety protocols around them?

_____

_____

Is there any history past or present of abuse or violence? YES ☐ NO ☐
If so, please explain:

_____

_____

Is your child currently using any illegal drugs or is the reason you are seeking therapy services substance related? Yes ☐ No ☐

_____

_____

Has your child ever witnessed or experienced a trauma? Yes ☐ No ☐
Does your child have reoccurring nightmares, flashbacks, or avoids anything that is uncomfortable or painful? If so, please explain:

_____

_____

Are you concerned your child may see or hear things that don't appear to be real? If so, please explain: Yes ☐ No ☐

_____

_____

Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put him/her at risk? If so, please explain? Yes ☐ No ☐

_____

_____

Do you have any concerns about your child's sexuality, gender or sexual development? Yes ☐ No ☐

_____

_____

Education, Responsibility, Recreation and Leisure

What school does your child attend? _____

What grade is your child in? _____

How are your child's grades? _____

Has your child ever been held back or receive specialized academic services? If so, for what?

_____

What concerns if any do you have about your child's education or schooling (grades, peers, relationships with teachers, etc)?

_____

_____

What would your child say he/she likes and dislikes about school:
Likes: _____
Dislikes: _____

What responsibilities does your child have at home?

_____

_____

If your child is age 15 yr. and above what other skills do you think your child needs to be independent? How is he/she learning them? What else does he/she need to gain independence?

_____

_____

What other responsibilities or skills would you like to see your child have/achieve?

_____

_____

Does your child have his/her own cell phone? YES ☐ NO ☐

What are the rules around your child's cell phone use? Who enforces those rules?

_____

Parent's marital status:

Married☐ Divorced☐ Never Married☐ Separated☐ Domestic Partners☐ Widowed☐

If 1 or both parents are absent, if so for how long and reason for absences:

_____

_____

If parents are not together please describe the parents' relationship with one another:
_____
_____

Who lives in the house with the child?
_____
_____

If parents are not together who lives in the other house with the child?
_____
_____

Does your family have any pets? If yes, names, types and relationship to each pet:
_____
_____

List 5 or more strengths of your family:
_____
_____

Is there anything that gets in the way of your family being the way you want it to be?
_____
_____

Describe your child's relationship with the following:
Mother: _____
Father: _____
Siblings: Age, Name and Sex:

a. Sibling 1 _____
b. Sibling 2 _____
c. Sibling 3 _____
d. Sibling 4 _____

Significant Other:
_____
Other(s): _____

Does your family belong to any religious or spiritual groups? YES ☐ NO ☐
If yes, what is your level of involvement?
_____

Who else do you consider to be part of or supportive to your family (people or affiliations):
_____

Is there any thing else that you think is important for me to know about your child?

_____

_____

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