

Intake Date _____

Case # _____

CHILD INTAKE INFORMATION

Patient Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____
Street City State Zip

School: _____ Grade: _____

Parent/Guardian: _____

Please circle: Mother/Guardian Age Father/Guardian Age
Parent's Address if different: _____

Stepparent(s) that live with child (if applicable): _____

Father/guardianHome: _____
Work: _____
Cell: _____Mother/guardianHome: _____
Work: _____
Cell: _____Child (if applicable)

Cell: _____

Father/Guardian Present Employer: _____

Occupation: _____ Soc. Sec. #: _____

Driver's License #: _____

Mother/Guardian Present Employer: _____

Occupation: _____ Soc. Sec. #: _____

Driver's License #: _____

Please circle form of payment: Cash Insurance

Primary Insurance Policyholder's Name Relationship Policyholder DOB

Contract Number Group Number Policyholder's Employer Policyholder SSN

Secondary Insurance Policyholder's Name Relationship Policyholder DOB

Contract Number Group Number Policyholder's Employer Policyholder SSN

timeliness of scheduling your first appointment:

Excellent	Good	Fair	Poor	Very Poor
5	4	3	2	1

Please rate the

****FOR STAFF USE ONLY****

**DSM-IV

Code

Therapist Signature

Print Name:

Therapist Code

Insurance	Deductible	Copay	Yearly maximum	Lifetime max
Primary				
Secondary				

If applicable:

Authorization #: _____ Number of sessions: _____ Dates covered: _____

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Please briefly state why this child was brought to the clinic. What are your concerns?

Has your child been seen by any other persons for this problem? Please explain. _____

Education and School History

Please provide the following information for all schools that the child has attended:

School	Year started	Year stopped	Graduated?
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is your child's attitude about school? About the teacher(s)? About other students? _____

How would you describe your child's performance and behavior at school? Are there any problems?

Financial Status

Family's overall financial status (including gross annual income, major assets/liabilities, number of dependents, etc.): _____

Developmental History

How would you describe the pregnancy with this child? _____

Were there complications? If so, explain: _____

Birth weight: _____

Were there any difficulties in infancy with (please circle):

Feeding	Yes	No
Weight gain	Yes	No
Sleeping	Yes	No
Weaning from breast/bottle	Yes	No
Crying	Yes	No

When did your child first (age):

Sit	_____
Walk	_____
Say a word	_____
Say simple sentences	_____

Describe and give age of any significant illnesses, including ear infections, high fevers, operations, and/or accidental injuries: _____

Describe any problem behaviors or personality difficulties as a preschooler: _____

Has your child had any traumatic or potentially traumatic experiences? If so, explain: _____

During the past year, have there been any significant events which might have had a negative effect on your child? If so, explain. _____

Legal Problems

Does the family have any pending legal problems? Yes No

Have you had prior legal problems in any way associated with your seeking treatment for your child at this time? Yes No

If yes to either of the above, please explain: _____

Culture, Ethic, and Religious Information

Does your family or your child currently, or have you or your child in the past, practiced a particular religion? Yes No

If yes, please provide additional information about the religion, your current level of involvement, and your anticipated interest in this in the future: _____

Does your family identify with particular cultural or ethnic groups? Of what overall importance is this in your family's life? _____

Present Family Constellation

Names/Ages/Sex of Siblings. Please indicate if any siblings reside in other than the child's residence.

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list any other persons living with the family: _____

Have there been any significant separation, divorces, deaths, etc., in the child's life? _____

Activity Assessment

Approximately how much time does your child spend on play and leisure activities on a typical week day? _____ hours per day.

Approximately how much time does your child spend on play and leisure activities on a typical weekend (Saturday and Sunday)? _____ hours per day.

Is the amount of leisure time your child has available (check one):

Less than adequate _____ Adequate _____ More than adequate _____ Much too much _____

With regards to the ways your child spends leisure time, would you say your child is (check one):

Very dissatisfied _____ Less than satisfied _____ Satisfied _____ More than satisfied _____ Very satisfied _____

Please list the activities in which your child is most active, starting with the activity in which he/she spends the most time? Include activities such as homework, individual or group play, chores, church activities, watching TV, computer, household projects, etc.)

Activity	Approximate number of hours per week
1.	
2.	
3.	
4.	
5.	
6.	

Are there activities you would like to see your child involved in? _____

Are there activities your child has expressed interest in, but is not presently involved in? _____

Medical History

Name, address, and phone number of current or most recent medical doctor: _____

What was the date of your child's last physical examination? _____

Height: _____ Weight: _____

Please list all current medications:

Name of medication	Dose	Frequency taken	How long taken	Who prescribes

Please check "yes" or "no" to indicate whether or not your child uses the following non-medical or non-prescribed drugs. For "yes" answers, please indicate usage:

	Yes	No	How much	How long
Cigarettes				
Sleeping pills				
Tobacco				
Alcohol				
Marijuana				
Cocaine, crack				
Inhalants				
Stimulants (e.g., "uppers")				
Aspirin or other pain medication				
Cold remedies, cough medicine				
Coffee				
Tea				
Cola				
Other:				

Does your child have physical pain? Yes _____ No _____

If yes, please rate the intensity of the pain: 1 (mild) to 5 (severe): _____

If yes, where is the pain located? _____

If yes, how does it affect your child's functioning? _____

Please check either "yes" or "no" to indicate whether or not the family has any of the following health problems. (Any unanswered questions will be considered a "no" response.)

	Child	Mother	Father	Siblings	Extended family member
Seizure disorder/epilepsy					
Glaucoma					
Emphysema					
Asthma					
Heart trouble					
High blood pressure					
Stomach trouble/ulcers					
Tuberculosis					
Thyroid disease					
Liver disease					
Gall bladder					
Hepatitis					
Diabetes					
Pancreatitis					
Cancer or tumor					
Arthritis or rheumatism					
Alcohol and/or drug abuse					
Stroke					
Anemia					
Depression					
Anxiety					
Mania or bipolar disorder					
Schizophrenia					
Learning disorder					
Attention deficit/hyperactivity disorder					
Other:					
Other:					

Is there any other medical, psychiatric, or substance abuse information that you feel we should know?

Is there anything else that you think we should know about your child or your family? _____

Signature: _____

Parent/guardian

Date

For therapist use only:

If it has been over a year since the child/adolescent's last physical, did you suggest that the child/adolescent have a physical? Yes _____ No _____ Did the parent/guardian agree to this? Yes _____ No _____

Therapist signature: _____

Date: _____

REV. 807

CHILD/ADOLESCENT SYMPTOM CHECKLIST

Date: _____

Name of the child: _____ Date of Birth: _____ Age: _____

Name of the person completing this form: _____ Relationship to child: _____

Please circle the symptoms that apply to this child in the past few weeks:

	Never	Rarely	Sometimes	Always									
Hyperactive	0	1	2	3	4	5							
Fidgety	0	1	2	3	4	5	Interrupted sleep	0	1	2	3	4	5
Difficulty sitting still	0	1	2	3	4	5	Early morning waking	0	1	2	3	4	5
Short attention span	0	1	2	3	4	5	Oversleeping	0	1	2	3	4	5
Easily distracted	0	1	2	3	4	5	Depression	0	1	2	3	4	5
Forgets easily	0	1	2	3	4	5	Mood swings	0	1	2	3	4	5
Does not turn in assignments	0	1	2	3	4	5	Crying spells	0	1	2	3	4	5
Disorganized	0	1	2	3	4	5	Irritability, edginess	0	1	2	3	4	5
Poor grades	0	1	2	3	4	5	Excessive worry	0	1	2	3	4	5
Academically behind	0	1	2	3	4	5	Low energy, tired	0	1	2	3	4	5
Learning difficulties	0	1	2	3	4	5	Loss of appetite	0	1	2	3	4	5
Speech problems	0	1	2	3	4	5	Overeating	0	1	2	3	4	5
Reading difficulty	0	1	2	3	4	5	Weight gain or loss	0	1	2	3	4	5
Math difficulty	0	1	2	3	4	5	If so, how much in the last 3-6 months: Gained _____ Lost _____						
Defies authority	0	1	2	3	4	5	Lack of interest in	0	1	2	3	4	5
Loses temper	0	1	2	3	4	5	usual things						
Argumentative	0	1	2	3	4	5	Difficulty separating	0	1	2	3	4	5
Gets angry easily	0	1	2	3	4	5	Won't sleep in own bed	0	1	2	3	4	5
Gets into fights	0	1	2	3	4	5	Fears of ordinary things	0	1	2	3	4	5
Throws or breaks objects	0	1	2	3	4	5	For example, storms, crowds, doctor, germs, closed spaces, flying)						
Problems with temper	0	1	2	3	4	5	Excessive hand washing	0	1	2	3	4	5
Homicidal thoughts	0	1	2	3	4	5	Rituals that child must do	0	1	2	3	4	5
Suicidal thoughts	0	1	2	3	4	5	For example, need to check and recheck; things in a certain order						
Suicidal attempts, gestures	0	1	2	3	4	5	Counting behavior, thoughts	0	1	2	3	4	5
Hurts animals	0	1	2	3	4	5	Need for organization, cleanliness	0	1	2	3	4	5
Lies	0	1	2	3	4	5	Anxiety, nervousness	0	1	2	3	4	5
Sets fires	0	1	2	3	4	5	Panic/anxiety attacks	0	1	2	3	4	5
Steals, shoplifts	0	1	2	3	4	5	Headaches	0	1	2	3	4	5
Breaks curfew	0	1	2	3	4	5	Stomachaches	0	1	2	3	4	5
Runs away from home	0	1	2	3	4	5	Unexplained physical symptoms	0	1	2	3	4	5
Skips school	0	1	2	3	4	5	Dizzy spells	0	1	2	3	4	5
Smokes	0	1	2	3	4	5	Suspiciousness, paranoia	0	1	2	3	4	5
Uses alcohol	0	1	2	3	4	5	Hears voices (that others don't)	0	1	2	3	4	5
Uses drugs	0	1	2	3	4	5	Sees things (that others don't)	0	1	2	3	4	5
Legal problems	0	1	2	3	4	5	Wets bed	0	1	2	3	4	5
Is or has been on probation	0	1	2	3	4	5	Soils underclothing	0	1	2	3	4	5
Is or was in juvenile detention	0	1	2	3	4	5	Eating disorder	0	1	2	3	4	5
Problem making or keeping friends	0	1	2	3	4	5	Picky eater	0	1	2	3	4	5
Sleep disturbance	0	1	2	3	4	5	Binge-eating, purging	0	1	2	3	4	5
Trouble falling asleep	0	1	2	3	4	5	Anorexia	0	1	2	3	4	5
							Trauma, other abuse	0	1	2	3	4	5