

Child/Adolescent Intake

Date of Intake:

Client Name:

DOB:

Who is accompanying minor?

Referred By:

Presenting problem:

How long has this been a problem?

Does child and parent/guardian agree on presenting issue?

Circle the symptoms your child/adolescent displays and list the number of times per week it is displayed:

Anger Anxiety Bed wetting Acts out sexually Conduct problems Controlling Defecation
Has unusual sexual knowledge Day wetting Defiance Depression Homicidal thoughts
Disassociates Drug or alcohol use Hyperactivity Masturbates excessively Hyper –
vigilance Impaired conscience Isolation Lack of empathy Lack of motivation Lethargy
Low impulse control Plays out violent themes Low self-esteem Lying Nightmares
Plays out sexual themes Obsesses Over/Under eating Phobias Peer problems
Running Away Shy Sleeplessness Stealing

Tantrums Somatic Symptoms: Headaches/Stomachaches, etc. Other:

Previous treatments?

Suicidal/Self-Harm Behaviors (describe specific behaviors including frequency, duration, intensity)

If suicidal, identify which are present (suicidal ideations and communications, suicide-related expectancies and beliefs, suicide-related affect)

How long have these behaviors been observed/present?

Hospitalizations (when and where?):

Current medications (type, dosage, frequency):

Physical Health History:

Developmental and Birth History:

Medical History During pregnancy, did mother use: __ Cigarettes, __ Alcohol, __ Drugs, __

List any birth complications (Ex: Premature, jaundice, C-section, etc)

Abuse and/or Trauma History:

Has your child been verbally abused? __Y, __N, __Suspected. Specify:

Has your child been physically abused? __Y, __N, __Suspected. Specify:

Has your child been sexually abused? __Y, __N, __Suspected. Specify:

Other Stressors or Traumas or Significant Losses?

Sexual History:

How many Partners?

Sexually Active?

Legal History:

School History:

Family Information (who lives in home, sisters, brothers, relatives who are in contact)

Relationship with mother:

Relationship with father:

Relationship with siblings:

Friends:

Describe the discipline in your home (who does, how do you respond):

Does your family have specific spiritual beliefs?

Does child use: ___ Cigarettes, ___ Alcohol, ___ Drugs

Interests/Hobbies:

What do you like about yourself?

Strengths:

What would you like to change?

Future Goals of child and family: