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Intake Form for Children and Adolescents

Today's Date: ____________________

Child's Name:____Child's DOB:________________________
Age:________ Gender Identity:___________________ Race/Ethnicity: ___________________________
How were you referred to us? : ____
Any current/potential legal involvement in your situation? ________ If yes, list the names of the law firms involved?: ____

Parents/Guardians:

(1)Name:____
Address:____
____
DOB:_____________________________________Cell #:____
work #____________________________________ Home #____
Email:____
Occupation: ___________________________ Relationship to child _________________________________

(2)Name:____
Address:____
____
DOB:_____________________________________Cell #:____
work #____________________________________ Home #____
Email:____
Occupation: ___________________________ Relationship to child _________________________________

Who has (singular or joint) legal custody of this child?:____

Other emergency contacts or primary caretakers (stepparents, grandparents, partners, etc.)

Name:____
Address:____
____
Cell #):__________________________________work #____________________________________
Home #: __________________________________Email:____
Relationship to child ____

School information:

Name of school: ____Grade in school: _______________
School Address: ____
School Phone #: ______________________________ Current Teacher: _________________________
School Counselor Name & Phone # (if relevant): ____
Is your child classified? _____ No _____ Yes - Classification/Diagnosis: ___________________________
Child Study Team Case Manager Name & Phone #: ____

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Please list household members' names, ages, and relationships to the child:
____
____

Please list any other important people in your child's life and their relationship to them:
____
____

Presenting Problems:
Why are you bringing your child to treatment at this time? What are the main concerns?
____
____
____
____

Recent stressors in the family – please check all that apply:

____ Change of residence
____ Change in caregivers' employment
____ Loss of job for parent/guardian
____ Money problems
____ Drug abuse
____ Alcohol abuse
____ Gender identity/sexual orientation
____ New school/change in school for child
____ Family member or close friend moved away
____ Child has seen others get hurt, beaten up or killed
____ Birth of family member
____ Friend died or tried to kill self
____ DCPP involvement with family
____ Sibling leaves home
____ Family member's mental illness
____ Siblings not getting along
____ Physical illness in family member
____ Close family member in jail/prison
____ Homeless/no long-term home
____ Legal problems
____ Couple/marital problems
____ Marital affair
____ Separation
____ Divorce
____ Remarriage
____ Adjusting to stepsiblings
____ Domestic violence
____ Child recently hospitalized
____ Death of family member
____ Sexual abuse/rape of family member
____ Wedding in the family
____ Other ________________________

Describe any ***stressors*** that may currently be affecting your child:
____
____

Does your child have any history of ***suicidality or self-injurious behavior*** (i.e., cutting self, burning self, starving self, binging, and purging)? If yes, please describe: ____________________________________
____
____

Does your child have any history of ***harming anyone else physicall***y or of ***destroying things*** (i.e., punching holes in walls, breaking down a door, fire-setting): ___________________________________
____
____
____

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Has your child ever had any **legal problems** (i.e., arrests, juvenile detention, etc.)? If yes, please describe:
____
____

Does your child have any history of using or abusing **tobacco, alcohol, marijuana, or other drugs**? If yes, please describe and list any history of treatment for this problem: ______________________________
____

Does your child have any history of being **sexually or physically abused or neglected**? If yes, please describe: ____
____

Prenatal/Neonatal Developmental History

Were there any complications during pregnancy or delivery? ________________________________
Were there any delays in reaching developmental milestones (i.e., sitting, crawling, walking, feeding self, speech, talking, toilet training etc.) or other early concerns about your child? :_____________________
If yes, please describe:____
____

Childs Psychiatric Treatment History:

What previous history, if any, has your child experienced with psychotherapy (i.e., seeing a school counselor, individual or family counselor, partial hospitalization program or inpatient treatment)? :
____
____

Please list the names and phone #'s of any previous treaters.:
____
____

Family History:

Please check below if anyone in your immediate or extended family has experienced the following and list the family member(s) for whom it applies:

- ____ Developmental disability/Autism ____
- ____ Physical disability ____
- ____ Depression ____
- ____ Bipolar Disorder/ ____
- ____ Anxiety ____
- ____ Psychosis/Schizophrenia ____
- ____ Suicide attempts ____
- ____ Completed suicide ____
- ____ Alcohol addiction ____
- ____ Drug addiction ____
- ____ Learning difficulties ____
- ____ Attention problems/ADHD ____
- ____ Physical Abuse ____
- ____ Sexual Abuse ____
- ____ Eating disorders ____

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Names of therapists for other family members: ____
____
____

Medical History:

Child's Physician's Name: ____
Physician's Phone #: ____
Child's Psychiatrist's Name (if applicable): ____
Psychiatrist's Phone #: ____
Child's current and past medical problems: ____
____
____

List all of the child's current psychiatric and medical medications (with dosages, prescribing doctor and for what illness/problem: ____
____

Child's medication allergies:____
____

Other allergies: ____
____

Please list any significant past medical problems, injuries, surgeries, or medical hospitalizations your child had with dates: ____
____

Other Pertinent Information:

Languages spoken at home: ____
Religious affiliation? :____
Is your child adopted? ____No _______ Yes. If so, at what age? ___________________________________
Is anyone else in the family adopted? ____ No ____ Yes. If so, who? _______________________________
Is your child or family currently involved with DCPP? ____ No ____ Yes. If so, please provide the name & phone # of case worker: ____

What are your child's strengths? ____
____
____

Please add any other information you feel is important for me to know: ___________________________
____
____
____
____
____
____
____
____
____

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