Child-Adolescent Intake

Please provide the following information about your child:

Child's Full Name:	Nickname:
Birth Date:	Today's Date:
Child's Address:	Phone:
Parent(s) names or primary guardian:	Parent(s) contact numbers: Home: Cell: Work:
In case of emergency, who may I contact on your behalf?	Name:
Phone number:	Relationship:

Education History

What school does your child attend:	Teacher's Name:
Current Grade:	Has your child ever repeated a grade? YES/ NO If so which one(s)_____
Favorite Subject:	Least Favorite Subject:
Does your child receive special education service? YES /NO	Does your child receive tutoring? YES/ NO
Is your child in a gifted/talented/honors program? YES/ NO	Does your child like school? YES/ NO
Has your child experienced any of the following at school? (please circle all that apply) Fighting, suspension, lack of friends, gang influence, learning disabilities, incomplete homework, drug/alcohol, poor attendance, behavior problems, detention, poor grades	
Has your child been the victim of bullying or bullied other children? YES/ NO. If yes, please describe:	

Please, use the space to provide any other additional information regarding your child's education or developmental history that you find significant:

Medical History

Pediatrician's Name:	Phone:
Is child under the care of another medical specialist? YES/NO If yes, type of specialist _____	Phone:

Please list any chronic illness, disabilities, medical conditions that your child has been diagnosed with:

Illness/Disability:	Dates:

List all medications that your child is currently taking:

Medication:	**Dosage:**	**Treating:**

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Therapy / Psychiatric Experience

Is your child *currently* seeing another therapist? YES / NO			
If yes, who are you seeing?			
Has your child ever been in therapy in the past YES/ NO			
If yes, please fill out the following on your previous counseling experience(s)			
Therapist	Location	Dates	Reason
Has your child ever had a psychiatric hospitalization? YES/ NO			
If yes describe briefly and indicate dates and circumstances			

Is your child under the care of a psychiatrist: YES/ NO	If yes, Psychiatrist name:
Phone:	Address:

Other History

Has your child ever experienced any type of abuse (physical, sexual, or emotional)? YES/ NO If yes, please describe:
Has your child ever made statement of wanting to him/her self or seriously hurt someone else? YES/ NO Has he/she purposely hurt himself or another? YES/ NO If yes, to either question please describe the situation:
Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? YES/ NO. If yes, please explain:

Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets him/her in trouble? YES/NO. If yes, please describe:
Are there any behaviors that your child fails to do as often as you would like or when you would like?
Please list positive strengths of your child: (What do you like about your child? What do others like about your child?)
How would you describe your child's self-esteem?
Briefly describe your reason(s) for seeking help at this time?
What goals do you wish to accomplish during the therapy process as a parent?
What goals does your child wish to accomplish during the therapy process? (can be different than parent's response)

Family History

Mother's Name Occupation:		Father's Name: Occupation:	
Step-Mother?		Step Father?	
Who does your child currently live with?			
Names	Age	Relationship to child	Grade/Job
Who are your child's significant others NOT living with your child?			
Names	Age	Relationship to child	Grade/Job

Are child's parents'? Married Separated Divorced Widowed (please circle one) If parents divorced/separated please list dates:
Who in the family is your child closest too?
What are some of the strengths of your family?
Does anyone in the child's family been diagnosed with a mental illness? YES/ NO If yes, please describe: