Intake Assessment Adolescent/Child

Please use the back of this form if need more room to complete questions

Date: _____

Client name: _____ Date of Birth: _____ Age: _____

Mother's Name_____ Employer _____

Address _____ City _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Father's Name:_____ Employer _____

Address _____ City _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Child's School Name_____ School Phone_____

Pediatrician_____ Phone#_____

Emergency Contact (Nearest relative or friend)_____ Phone _____

Person Financially Responsible _____SS# _____

Preferred Language of Patient:_____

Referral Source:_____

☐ **Victom's Compensation County: _____**

Please describe in detail why you are pursuing therapy at this time including background regarding the primary concern.

Check all symptoms that apply to client past or present:

- ❏ **Anxiety:** ☐ excessive worry ☐ fear of impending harm ☐ panic attacks restlessness ☐ sweaty hands ☐ nightmares ☐ school anxiety ☐ difficulty with transitions ☐ separation anxiety ☐ racing heart ☐ difficulty breathing
- ❏ **Appetite:** ☐ eats too much ☐ eats too little ☐ overweight ☐ underweight ☐ restrictive diet
- ❏ **Nutrition Problems:** ☐ unhealthy choices ☐ cravings ☐ large portions
- ❏ **Attention:** ☐ Attention Deficit/ Hyperactivity ☐ poor attention ☐ disruptive ☐ easily description easily distract ☐ forgetful ☐ does not listen ☐ in impulsive ☐ hyperactive ☐ fidget ☐ unable to stay on task ☐ excessive talking ☐ poor follow-through tasks ☐ avoidance of tasks that require sustained mental effort ☐ difficulty with organization ☐ interrupts or intrudes on others ☐ impatient ☐ loses things
- ❏ **Autism:** ☐ Abnormal Body Posturing or Facial Expressions ☐ Abnormal Tone of Voice ☐ Poor Eye Contact ☐ Behavioral Disturbances ☐ Deficits in Language Comprehension ☐ Delay in Learning to Speak ☐ Flat or Monotonous Speech ☐ Inappropriate Social Interaction ☐ Intense Focus on One Topic ☐ Lack of Empathy ☐ Lack of Understanding Social Cues ☐ Learning Disability or Difficulty ☐ Not Engaging in Play With Peers ☐ Preoccupation With Specific Topics ☐ Problems With Two-Way ☐ Conversation ☐ Repeating Words or Phrases ☐ Repetitive Movements ☐ Self-Abusive Behaviors ☐ Sleep Disturbances ☐ Social Withdrawal ☐ Unusual Reactions in Social Settings ☐ Odd Words or Phrases
- ❏ **Conduct Problems:** ☐ aggressive ☐ oppositional ☐ defiant ☐ assaulted ☐ explosive temper ☐ disobeys rules ☐ argumentative ☐ threatens others ☐ bullies/ intimidates ☐ blames others for Behavior ☐ deliberately annoys others ☐ easily annoyed ☐ angry ☐ resentful ☐ excessively negative ☐ difficult to manage
- ❏ **Depression:** ☐ depressed mood ☐ sad ☐ irritable ☐ mood reactivity ☐ low self-esteem ☐ cheerfulness ☐ energy/ fatigue ☐ poor concentration ☐ hopelessness ☐ restlessness ☐ decreased energy ☐ hopelessness ☐ worthlessness
- ❏ **Dissociative:** ☐ stairs off ☐ periods of not answering questions when talked to ☐ amnesia ☐ not feeling connected to your own body ☐ developing different identities
- ❏ **Energy:** ☐ low energy ☐ high energy
- ❏ **Mania:** ☐ high energy/activity ☐ excessive talking ☐ increased goal-directed behavior
- ❏ **Obsessive/ Compulsive:** ☐ repetitive thoughts ☐ ritualistic behavior ☐ obsessive thinking/behavior
- ❏ **Psychosis:** ☐ delusions ☐ hallucinations ☐ paranoia

- ❑ **Somatic:** ☐ complaints of physical sickness ☐ frequent ailments
- ❑ **Sleep:** ☐ trouble falling asleep ☐ nocturnal awakenings ☐ naps
- ❑ **Suicide/Self-harm:** ☐ thoughts of suicide in the past ☐ current thoughts of suicide ☐ history of suicide attempt ☐ history of self-harm
- ❑ **Trauma:** ☐ victim of crime ☐ re-experiencing trauma ☐ sexual abuse
- ❑ **Grief:** ☐ crying ☐ lack of engagement ☐ recent loss
- ❑ **Relationship Difficulties**

Previous Mental Health History:

- ❑ **Participated in counseling in the past (list provider(s) and dates attended)** _____
- ❑ **Previous psychological testing (describe)** _____
- ❑ **Previous diagnosis** _____
- ❑ **Previous Hospitalization(s)** _____
- ❑ **Suicidal ideation:** ☐ thought ☐ plan ☐ intent ☐ self-harm ☐ attempt ☐ hospitalization
- ❑ **Past Psychotropic Medications:** _____
- ❑ **Residential Treatment** _____
- ❑ **Outpatient Treatment** _____

Birth History:

- ❑ Age of mother at conception _____
- ❑ Concerns during the course of your pregnancy _____
- ❑ Medication or drug use (including non-prescription drugs) during pregnancy_____
- ❑ Was baby full-term _____
- ❑ Were there any indicators of fetal distress during labor or birth _____
- ❑ Weight and APGAR scores, if known _____

Developmental History:

Were developmental milestones met at appropriate ages _____
Describe discipline used in the home _____
What is the client disciplined for_____
How does the client respond?_____
List chores/tasks the client is responsible for _____
List traumatic or frightening experiences the client has experienced _____

Medical History:

- ❑ List health concerns _____
- ❑ History of head injury with loss of consciousness _____
- ❑ History of Medical hospitalizations_____
- ❑ History of surgeries_____
- ❑ Medical diagnosis_____
- ❑ Date of last physical exam_____
- ❑ Weight fluctuations 10 lb within the last 3 months_____

- ❏ Special diet_____
- ❏ Food allergies_____
- ❏ Sleeps through the night _____
- ❏ Nightmares _____
- ❏ Bedwetting _____
- ❏ Goes to bed at _____
- ❏ Wakes up at _____
- ❏ Independent with bathing, dressing, and other self care _____

Family History:

Child lives at home with:
Name: _____ Age: ____
Name: _____ Age: ____
Name: _____ Age: ____
Name: _____ Age: ____
Name: _____ Age: ____
Name: _____ Age: ____

List biological parents names _____
If client's biological parents separated please describe _____
Custody arrangement _____
How long have you lived at your present location? _____
Describe times client has been separated from primary caregiver _____
List practicing religion _____
Describe child's relationship with the biological mother_____
Describe the client relationship with the biological father _____
Describe the clients relationship with their siblings_____
Describe the clients relationship with their step parents _____
List family members who have received therapeutic services _____
List family members who have mental health diagnosis _____
List family members who have a medical diagnosis_____

Interests/Activities:

Describe the client_____
Describe the clients friends_____
Favorite classes/ activities_____
Sports/extracurricular participation in school_____
Current employment_____
Hobbies_____
Hours/day of technology (TV, computer games, video games)_____
Weekly physical activities outside of school_____

Educational History:

Current grade_____
List school currently attend_____
List other schools and dates of attendance_____

Individualized education plan (IEP) special education designation or 504_____
Estimated grade point average _____
List learning difficulties_____
Does the client complete home work independently _____
Has the client experienced any traumatic experiences at school _____
Client's career aspirations _____

Sexual History:
Sexual orientation _____
Romantic interest _____
Currently dating _____
Sexually active _____

Trauma/Abuse:
Describe trauma/ abuse history_____

Legal Involvement:
- ❑ Client has some legal history_____
- ❑ Caregiver current legal involvement_____

Substance Use History:
- ❑ Client currently uses substances (list) _____
- ❑ Client used substances in the past (list)_____
- ❑ When did substance abuse start _____
- ❑ How have you intervened _____

Family Psychiatric History:
- ❑ Siblings_____
- ❑ Biological mother _____
- ❑ Biological father _____
- ❑ Other family members _____

Current Medications
- ❑ Over-the-counter medications, vitamin supplements _____
- ❑ Prescriber name and phone number _____

Other:
Describe any other information that is important to know _____