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Child & Adolescent Intake

Person completing form: ______________________________________ Date: _____/______/_______

Your relationship to this child: ____

Are you this child's legal guardian? Y ___ N ___; If no, please explain: ________________________________

Name of Child: ____ Date of Birth: ____/____/____ Age: _____

What does child like to be called: ___________________________________ Gender: Female ___ Male ___

Child's address: ____

School: ____ Grade: _____ County: _____________________

Does this child receive any special education services? No ___ Yes ___; if yes, please specify ______________
____

Mother's Name: __________________________________
Biological __ , adopted ___, step ___, foster ___, other ___________

Address: Same as above ___
If different: ______________________________
____
____

Contact Information OK to contact?

Telephone: (H) _____ / _______ - ___________ ___
(W) _____/ _______ - ___________ ___
(C) _____ / ______ - ____________ ___

Text: same as cellular listed above ____ ___
Different _____/ _____-__________ ___

E-Mail: ______________________________________
Only provide if OK to contact via e-mail

Father's Name: ______________________________
Biological __ , adopted ___, step ___, foster ___, other _______

Address: Same as above ___
If different: ______________________________
____
____

Contact Information OK to contact?

Telephone: (H) ____ / ______ - ________ ___
(W) ____ / ______ - ________ ___
(C) ____ / ______ - ________ ___

Text: same as cellular listed above ____ ___
Different _____/ _____-__________ ___

E-Mail: _________________________________
Only provide if OK to contact via e-mail

With whom does this child live? ____

Siblings

Please list all brothers and sisters of this child:

Name of Sibling	*Age*	*Brother or Sister (please specify if half- or step-brother/sister)*	*Living at home?*

BIRTH & DEVELOPMENT

Birth weight: _____lbs., _____oz. Length of Pregnancy: ________________ Apgar score: _____

Handedness: Right ___ Left ___ Ambidextrous ___

Were there any complications that occurred during the pregnancy or birth of this child? No ___ Yes ___ ; If yes, please explain: ____
____
____

Did this child spend anytime in NICU? No ___ Yes ___; if yes, how long and please explain the circumstances? __________
____
____

Did this child experience any developmental delays; e.g., crawling, walking, speaking, feeding, fine/gross motor movement, etc. No ___ Yes ___ Not sure ___; if yes or not sure, please explain: ____________________________________
____
____

MEDICAL INFORMATION

Name of Pediatrician: ____ Telephone: ________________________
Address: ____

Date of most recent physical exam: ________________________ Results: ___________________________
Date of most recent vision exam: __________________________ Results: ___________________________
Date of most recent hearing exam: _________________________ Results: ___________________________

Are there other health professionals involved with this child? No ___ Yes ___; if yes, please provide their names, specialties, contact information, and reasons why this child is seeing them.

Health Professional #1
Health Professional #2
Health Professional #3

Please list any medications this child is taking and for what reason:

Medication	Dosage	Reason

Please list any serious illnesses or operations/surgeries that this child has had or been through and at what age:
____
____
____

Has this child ever sustained a head injury, lost consciousness, had a concussion and/or been in a coma? If yes, please explain by including the incident, age, and outcome.
____
____
____

Mental Health History

Has this child ever been under the care of a mental health professional; e.g., psychiatrist, psychologist, social worker, counselor, etc. ? No _____ Yes ______ If yes, please explain: ________________________________
____
____
____

Has this child ever had a psychiatric or psychological evaluation? No ______ Yes ______; If yes, please provide the following information:

Who conducted the most recent evaluation? ____________________________________ When? _______________

For what reason? ____

What was the outcome of the evaluation? ____
____

Do you have a copy of the report? Yes ___ No ___

Were there other psychological evaluations previous to this one? Yes ___ No ___

REASON for REFERAL

Were you recommended to seek help for this child from any of the following? YES NO

	YES	NO
Teacher/School/Educational Facility:	____	____
Pediatrician/Medical Professional:	____	____

What type of service(s) are you seeking for this child?

Educational/Behavioral Evaluation ◯

Specifically:

Gifted Testing ___

Learning Disorder ___

Attention Deficit/Hyperactivity Disorder ___

Autism Spectrum ___

Other ________________________________

Counseling/Therapy ◯

For: ______________________________

____

____

____

____

Please refer to page 5 to complete the Typical Problems of Children and Adolescents Form.

Additional Information/Comments:

To the best of my knowledge, the information completed on this intake is accurate.

____ ____________________________

Signature of Parent or Guardian Date

Typical Problems of Children and Adolescents Form

The following list includes typical problems of children at home and/or at school. Please check any of the following that apply to this child:

Behavior	**Currently exhibits** *Indicate in each box how long this has been occurring.*	**Exhibited in the past but NOT currently** *Indicate at what age or how long ago this occurred.*
Anxiety		
Fears/Phobias		
Inattentiveness		
Disobedience		
Academic Difficulty		
Aggression		
Depression		
Conflicts with Peers		
Conflicts with Teachers		
Sadness/Crying		
Low Concentration		
Drug Use		
Legal Conflicts		
Low Motivation		
Distractible		
Low Frustration Tolerance		
Bowel/Bladder Problems		
Under/Overeating		
Fire Setting		
Isolation/Withdrawal		
Sleep Difficulties		
Attention Seeking		
Lying/Cheating		
Speech Difficulties		
Temper Tantrums		
Hyperactivity		
Restlessness		
Running Away		
Accident Prone		
Imaginary Playmates		
Hears or Sees Things that are Not There		
Finger/Foot Tapping		
Repetitive Motor Movements; e.g., rocking, spinning, pacing, talking to one self, other self-stimulatory behavior(s)		
Interrupts Others		
Self-Injurious Behavior(s)		
Inappropriate Sexual Behavior		

What do you see as this child's main difficulty? ____