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Child & Adolescent Intake

Person Completing Form: _____ Date: _____/_____/_____

Your relationship to this child: _____

Are you this child's legal guardian? Yes __ No __; If No, please explain: _____

_____

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

What does this child like to be called? _____ Gender: _____

Child's Address: _____

School: _____ Grade: _____ County: _____

Does this child receive any special education services (504 plan, IEP, etc.)? No ___ Yes ___; if Yes, for what reason? _____

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

Address: Same as above ☐
If different: _____
_____

Contact Information OK to contact?

Telephone: _____/ _____ - _____ ___

Text _____/ _____-_____ ___
(If different from Telephone #)

E-Mail: _____ ___

Father's Name: _____
Biological __ , adopted __, step ___, foster __, other___

Address: Same as above ☐
If different_____
_____

Contact Information OK to contact?

Telephone: (H) ____/ _____ - _____ ___

Text _____/ _____-_____ ___
(If different from Telephone #)

E-Mail: _____ ___

With whom does this child live? _____

SIBLINGS Please list all brothers and sisters of this child:

First 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:_____

Were there any complications that occurred during the pregnancy or birth of this child? No ___ Yes ___:

If yes, please explain: _____

_____

Did this child spend any time in NICU? No ___ Yes ___, If yes, how long? _____

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: _____

_____

Handedness: Right __ Left __ Ambidextrous__ General Activity Level: Active __ Sedentary __
Has this child's activity level changed within the last 6 months? No ___ Yes ___; If Yes, please explain:

_____

MEDICAL INFORMATION

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 any other health professionals involved with this child? No ___ Yes ___; if yes, please provide their names, specialties, contact information and reason(s) why this child is seeing this health professional.

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

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

Medication	Dosage	Reason	Prescribed by?

Please list any serious illnesses or operations/surgeries that this child has had or been through, including history of anesthesia:

_____
_____
_____

Has this child ever sustained a head injury, lost consciousness, had a concussion and/or been in a coma? No ___. Yes ___; 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; i.e., 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 evaluation/report? Yes _____ No _____

Were there previous evaluations conducted on this child? No __ Yes ___

Please provide copies of all psychological/psychoeducational/neuropsychological reports.

Reason for Referral

Were you recommended to seek help for this child from any of the following?

	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 ___
Executive Function ___
Learning Disorder ___
Attention Deficit/Hyperactivity Disorder ___
Autism Spectrum ___
Other _____

Counseling/Therapy ◯

For: _____
_____
_____

In addition to completing the Typical Problems of Children and Adolescents Form on Page 5, please use this space to add any other information you would like me to know about your child and situation:

_____
_____
_____
_____
_____
_____
_____
_____

To the best of my knowledge, the information completed on this intake is accurate. I give my consent for you to communicate with this child, this child's doctors and other health professionals for the purpose of coordinating professional services. I understand that I may withdraw this consent by written notice to you at any time.

_____ _____
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:

	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; i.e., rocking, spinning, pacing, other self-stimulatory behavior(s)		
Self-Injurious Behavior(s)		
Inappropriate Sexual Behavior		
Excess Use of Technology		

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