The Psychological Health Collaborative, PLLC

Child/Adolescent Intake Form

Name: _____ Date: _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

Please check all your child's behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Sadness/depression
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Fatigue
- ☐ Recurring, disturbing memories
- ☐ Change in appetite
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Phobias
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Racing thoughts
- ☐ Wide mood swings
- ☐ Suspicion/paranoia
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Defiance
- ☐ Aggression/fights
- ☐ Homicidal thoughts
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Peer/sibling conflict
- ☐ Stealing
- ☐ Destroys property
- ☐ Running away
- ☐ Swearing
- ☐ Curfew violations
- ☐ Lying
- ☐ Other:_____
- ☐ Manipulative behavior
- ☐ No/few friends
- ☐ Eating problems
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Toileting problems
- ☐ Fire setting
- ☐ Work/school problems
- ☐ Legal problems
- ☐ Sexual behavior
- ☐ Computer addiction
- ☐ Alcohol/drug use
- ☐ Lack of motivation

Are your child's problems affecting any of the following?

☐ Handling everyday tasks ☐ Self esteem ☐ Relationships ☐ Hygiene ☐ Health
☐ Recreational activities ☐ Work/School ☐ Housing ☐ Legal matters ☐ Finances

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt him/herself? If yes, please describe: _____

_____

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

_____

☐ Yes ☐ No Has your child recently been physically hurt or threatened by someone else? If yes, please describe: _____

_____

☐ Yes ☐ No Has your child gambled in the past 6 months? If yes, let us know the following

☐ Yes ☐ No Has your child ever felt the need to bet more and more money?

☐ Yes ☐ No Has your child ever had to lie to people about how much your child has gambled?

Therapist Notes:
Init: ____

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Lives with Child?	Age	Quality of Relationship
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Other relatives				

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times _____
☐ Father remarried: Number of times _____

Please check if your child has experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

☐ Yes ☐ No Were there any medical problems during the pregnancy or birth of your child? If yes, please describe: _____

☐ Yes ☐ No Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? If yes, please describes substances used, quantity, and frequency: _____
_____

☐ Yes ☐ No Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? If yes, please describe: _____
_____

Therapist Notes:

Init: _____

Name: _____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

Therapist Notes:
Init: ____

SCHOOL INFORMATION

Current grade/placement: _____

This year's school grades:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Past school grades:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
This year's school behavior:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Past school behavior:	☐ Excellent	☐ Good	☐ Fair	☐ Poor

Has your child had any of the following difficulties at school?

☐ Suspension	☐ Incomplete homework	☐ Learning problems	☐ Referrals or detentions
☐ Poor grades	☐ Teased or picked on	☐ Speech problems	☐ Attendance problems
☐ Gang influence			

☐ Yes ☐ No Does your child have an after-school provider? If so, who? _____

☐ Yes ☐ No Has your child ever repeated or skipped a grade? If yes, which one(s)?_____

☐ Yes ☐ No Has your child ever received Special Education services? If yes, please describe services received and reason for services: _____

What does your child's teacher(s) say about him/her? _____

Therapist Notes:
Init: ____

Name: _____

SUBSTANCE USE HISTORY (for ages 12 and older or if applicable)

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

☐ Yes ☐ No Has your child had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

☐ Yes ☐ No Has your child ever had problems with work, relationships, health, the law, etc. due to his/her substance use? If yes, please describe: _____

Therapist Notes:
Init: ____

MEDICAL INFORMATION

Date of last physical exam: _____

Has your child experienced any of the following medical conditions during his/her lifetime?

☐ Allergies	☐ Asthma	☐ Headaches	☐ Stomach aches
☐ Chronic pain	☐ Surgery	☐ Serious accident	☐ Head injury
☐ Dizziness/fainting	☐ Meningitis	☐ Seizures	☐ Vision problems
☐ High fevers	☐ Diabetes	☐ Hearing problems	☐ Ear infections
☐ Miscarriage	☐ Abortion	☐ Sleep disorder	☐ Sexually transmitted disease

☐ Other: _____

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: ☐ None
If yes, please list: _____

Therapist Notes:
Init: ____

Name: _____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your child's social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one? _____)

To which cultural or ethnic group does your child belong? _____
If your child is experiencing any difficulties due to cultural or ethnic issues, please describe:_____
_____

How important are spiritual matters to your child? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much
☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your child's counseling?

Please describe your child's strengths, skills, and talents? _____
_____
Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____
_____

Therapist Notes:
Init: ____

LEGAL INFORMATION

If the parents are separated or divorced, what is the current child custody/visitation arrangement? _____
_____

☐ Yes ☐ No Is your child currently the subject of a custody case?
☐ Yes ☐ No Has your child ever been a ward of the court with SCF/DCFS guardianship?
☐ Yes ☐ No Does your child have any legal offenses on record or pending in the courts?

Therapist Notes:
Init: ____