CHILD & ADOLESCENT
INTAKE INFORMATION FORM

Form Completed By:	Date:

IDENTIFYING INFORMATION	
Child's Name:	( ) Female ( ) Male
Age: Birth date:	
School:	Grade:
Home Address:	Phone #:
Guardian 1 Name:	Relationship to Child:
Home Address:	Phone #:
Guardian 1 Employment:	Phone #:
Guardian 2 Name:	Relationship to Child:
Home Address:	Phone #s:
Guardian 2 Employment:	Phone #:
Primary Insurance Carrier:	Insurance Plan #:
Insured's Name	Insured's Relationship to Child:
Secondary Insurance Carrier:	Insurance Plan #:
Insured's Name	

REASON FOR VISIT
Referred by:
What happened that made you seek help at this time?

PERSONS LIVING WITH CHILD			
Name	**Relationship**	**Age**	**School/Employment**

FAMILY MEMBERS NOT LIVING WITH CHILD			
Name	**Relationship**	**Age**	**Where living? School / Employment**

FAMILY
Religious Affiliation: **Church-Related Participation/Activities:** **Other Spiritual Practices:**
Problems or concerns at home/with family:
Family Activities:
Describe child's relationship with his/her parents:
Describe child's relationship with his/her siblings:
Child's household chores and rules: **How do they do with chores and rules?**
What type of rewards and/or disciplines do you use with your child?

FAMILY HISTORY			
Has any family member:	**No**	**Yes**	**If yes, please explain.**
Had significant learning problems?			
Had significant health problems?			
Been in treatment for alcohol/drug abuse, depression, nervous breakdown, or other mental/emotional problem?			
Committed or attempted suicide?			
Been charged with a crime, served prison time, on probation?			
Been involved with Child Protective Services?			
Attended anger management classes/counseling?			

EARLY DEVELOPMENT	
Mother's age during pregnancy:	**Mother's health during pregnancy:**
While pregnant, was there use of cigarettes, alcohol, or drugs? ( ) No ( ) Yes **If yes, identify what used, quantity and frequency of use:**	
While pregnant was there use of prescription medication? ( ) No ( ) Yes **If yes, what kind?**	
Length of pregnancy: ( ) Full-term: + or – 2 weeks) ( ) Early: > 2 weeks) **( ) Late: > 2weeks) ( ) Early: > 2 weeks, specify:**	
Type of delivery: ( ) vaginal ( ) c-section	
Were there any complications or problems during the pregnancy, labor or delivery? **( ) No ( ) Yes If yes, please explain:**	
Birth Weight:	**Any problems after birth?**
Problems with crawling?:	**Age walked:**
Age talked:	**Age toilet trained:**
Any developmental concerns / delays? ( ) No ( ) Yes If yes, please describe:	
Personality/temperament as a baby/toddler:	
Services this child has received: ( ) Speech Therapy ( ) Physical/Occupational Therapy **Other therapies?:**	

HEALTH			
Has this child ever had:	**No**	**Yes**	**If yes, please explain when, how often and/or how serious:**
Serious Accident, Injury, Stitches, Unconsciousness			
Hospitalization			
Surgery			
Head Injury			
Seizures			
Allergies			
Asthma			
Diabetes			
Frequent Headaches			
Ear Infections			
Hearing Problems			
Vision Problems			
Elimination: constipation, diarrhea, bed-wetting, etc.			
Sleeping			
Other Health Problem			

Past Medication(s):	**For treatment of:**	
Current Medication(s):	**For treatment of:**	
Child's Primary MD Name:	**Date of last visit:**	**Purpose of visit:**

NUTRITIONAL INFORMATION			
Concerns for your child:	**No**	**Yes**	**If yes, please explain:**
Undiagnosed food allergies			
Significant eating/feeding problems			
Eating non-food items			
Significantly overweight or underweight			
Recent large weight gain or weight loss			

Current Weight:	**Current Height:**

MENTAL HEALTH			
Has this child ever had significant problems with:	**No**	**Yes**	**If yes, please explain.**
Attention, concentration, organization			
Impulsivity			
Over-activity			
Destructive Behaviors			
Aggression			
Anger			
Depression-Sadness			
Anxiety-Nervousness			
Odd thoughts or behaviors			
Getting along with peers			
Getting along with adults			
Other:			
Has your child ever:	**No**	**Yes**	**If yes, please explain.**
Had a psychological or psychiatric evaluation?			
Been given a psychiatric diagnosis?			
Been on medication for a mood or thought problem?			
Met with a therapist or counselor?			
Been in a special therapeutic program?			
Been psychiatrically hospitalized?			
Has tried to harm self or others?			
Other:			

SCHOOLING			
Name of School	**Grade level(s)**	**Special Education, Special Services? Please explain.**	**How did your child do – with grades, following instructions and in getting along with others?**

CHILD'S HISTORY			
Has this child experienced:	**No**	**Yes**	**If yes, please explain.**
Death of a friend?			
Death of a family member?			
Auto accident?			
Natural disaster?			
Seeing parents fight?			
Physical , sexual, or emotional abuse?			
Living away from family?			
Living in poverty?			
Other scary/upsetting events?			

CURRENT SITUATION		
How many close friends does your child have?	**Do they tend to be younger, older, same age?**	**Are they a good or bad influence?**
How does your child get along with peers?	**How well is your child able to make and maintain friends?**	
How is you child doing in school now – goes to classes, pays attention, completes work, behaves?		
Does your child have any learning problems?		
Does your child have any current medical condition or health problem affecting learning?		
Does or did your child have any criminal/legal problems – arrests, charges, court, detention, or probation officer?		
Has your child smoked cigarettes, used alcohol or illicit drugs? If yes, please explain.		
What are your child's favorite things or activities?		
Is your child involved in community sports/activities? If yes, what?		
What is your child good at? What are your child's strength's?		
What is your view of your child's personal and cultural identity?		
What are your expectations for your child?		
What changes would you like to see in your child?		
What changes would you like to see in yourself?		
What changes would you like to see in your family?		

LEARNING INFORMATION			
Primary language spoken in home: **Other learned languages:**			
	Child	**Mother**	**Father**
Highest grade completed.			
How do family members best learn new information: verbal, written, video, computer, other?			
What topics would you like information on?			

OTHER
Any concerns about pain management for your child?
Any financial hardships associated with your child's care?
Any other additional information or comments?

Thank you very much for taking the time to respond to these questions in the interest of your child.

KEY 17 March 05