



Child & Adolescent Intake

Person Completing Form: _____ Date: _____

Your relationship to child: _____

Are you this child's legal guardian? Yes No

If **No**, Please Explain: _____

Child Information

Name of Child: _____

What does this child like to be called? _____ Female Male

Date of Birth: ____ / ____ / ____ Age: _____ Phone: (____) ____ - _____

Home Address: _____

School: _____ Teacher: _____ Grade: _____

School Phone: (____) ____ - _____

School Address: _____

Where was the child born? _____ How long has the child lived in the USA? _____

Language(s) spoke in home? _____

Language most often spoken **TO** the child? _____ Language most often spoken **BY** the child? _____

Parent Information

Mother's Name: _____

Biological Adopted Step Foster Other _____

Address: Same as above

Father's Name: _____

Biological Adopted Step Foster Other _____

Address: Same as above

Contact Information: Ok to contact

Phone: (H) (____) ____ - _____ Best

(W) (____) ____ - _____ Best

(C) (____) ____ - _____ Best

Email: _____ Best

Contact Information: Ok to contact

Phone: (H) (____) ____ - _____ Best

(W) (____) ____ - _____ Best

(C) (____) ____ - _____ Best

Email: _____ Best

With whom does this child live? _____

Sibling Information

Please list all brothers and sisters of this child:

Name of Sibling	Age	Brother or Sister		Living at home	
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No

How does your child get along with family members? _____

How is your child disciplined? _____

How does your child get along with same-aged peers/ friends? _____

List any behavioral or social-emotional concerns you may have regarding your child. _____

Has your child ever experienced any major stressors or trauma? Yes No If no, explain: _____

What are your child's interests/hobbies? _____

What are your child's major strengths and positive traits? _____

Medical Information

Name of Pediatrician: _____ Phone: (____) _____ - _____

Address: _____

Are there other health professionals involved with this child? Yes No

If yes, please provide their names, specialties, contact information, and reasons why this child is seeing them.

1. Name: _____ Specialty: _____ Phone: (____) _____ - _____

Reason: _____

2. Name: _____ Specialty: _____ Phone: (____) _____ - _____

Reason: _____

3. Name: _____ Specialty: _____ Phone: (____) _____ - _____

Reason: _____

4. Name: _____ Specialty: _____ Phone: (____) _____ - _____

Reason: _____

Did this child experience any serious injuries, illnesses or hospitalizations? Yes No Not Sure

If yes or not sure, please explain including incident, age, and outcome:

Has this child ever sustained a head injury, lost consciousness, had a concussion and/or been in a coma? Yes No Not Sure

If yes or not sure, please explain including incident, age, and outcome: _____

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

Does your child wear glasses? Yes No Date of last exam: ____/____/____

Does your child wear a hearing aid? Yes No Date of last exam: ____/____/____

Does your child receive speech/language services, and/or is their cause for concern? Yes No

Birth & Development

Were there any complications that occurred during the pregnancy of this child? Yes No

If yes, explain: _____

Were there any complications that occurred during the birth of this child? Yes No

If yes, explain: _____

Did this child experience any developmental delays; i.e., crawling, walking, speaking, motor movement, etc.? Yes No Not Sure

If yes or not sure, please explain including 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.? Yes No

If yes, explain: _____

Has this child ever had a psychiatric or psychological evaluation? Yes No

If yes, please provide the following information:

Who conducted the evaluation? _____

When was it conducted? _____

For what reason? _____

Do you have a copy of the evaluation/report? Yes No

What was the outcome of the evaluation? _____

Educational History

List all schools your child has attended (include pre-school if applicable):

<u>Name of School</u>	<u>Location</u>	<u>Grades</u>	<u>Reason for Leaving</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Age student started kindergarten _____ Repeated a grade? Yes No
If yes, what grade? _____ Why? _____

Has your child ever been excessively absent from school (more than 15 days in one school year)? Yes No
If yes, what grade? _____ Why? _____

What are your child's feelings towards school? _____

What do you consider to be your child's major academic weaknesses/strengths? _____

When did any academic difficulties begin? _____

What is your child's behavior like in school? _____

What is homework time like for your child? _____

Reason for Referral

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

Teacher/School/Educational Facility: Yes No

Pediatrician/Medical Professional: Yes No

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

- Gifted Testing
- Learning Disability
- Attention Deficit / Hyperactivity Disorder
- Other _____

*Please refer to page 7 to complete the
Typical Problems of Children & Adolescents Form*

Additional Information/Comments:

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 & 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 <i>Indicate in each box how long this has been occurring.</i>	Exhibited in the past but NOT currently <i>Indicate at what age or how long ago this occurred.</i>
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, talking to one self, other self-stimulatory behavior(s)		
Interrupts Others		
Self-Injurious Behavior(s)		
Inappropriate Sexual Behavior		