



### Child/Adolescent Intake

Child Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Sex  Male  Female Age: \_\_\_\_\_

School attending \_\_\_\_\_ Grade (current or entering) \_\_\_\_\_

Is patient adopted? Yes No If yes, at what age? \_\_\_\_\_

Race/Ethnicity

- Caucasian  Native American  Multiracial \_\_\_\_\_
- African American  Asia  Latin or Spanish  Other \_\_\_\_\_

Biological Parents (or Guardian information):

Are Biological parents divorced or separated? Yes No If yes, for how long \_\_\_\_\_

**If yes, do parents share custody? Yes No \*\* Court documentation must be provided**

Parent: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: \_\_\_\_\_ okay to leave msg?  Yes  No

Occupation: \_\_\_\_\_

Email: \_\_\_\_\_ okay to use email?  Yes  No

Co-Parent: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: \_\_\_\_\_ okay to leave msg?  Yes  No

Occupation: \_\_\_\_\_

Email: \_\_\_\_\_ okay to use email?  Yes  No

Siblings (include biological, adopted, foster, step, etc.)

<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Type (bio,step,etc.)</u>	<u>Custody?</u>
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Anyone else living in your household other than parents or siblings? Yes No

\*\*\*If yes, please give name(s) and relationship:

\_\_\_\_\_

Person to contact in case of emergency

Phone Number

\_\_\_\_\_



**COUNSELING HISTORY OF CHILD/ADOLESCENT**

**Prior counseling experience:**

From: \_\_\_\_\_ To: \_\_\_\_\_ With Whom? \_\_\_\_\_

How were you referred to me? \_\_\_\_\_

Is there any history of mental health issues or concerns in the family? (if yes, please describe) \_\_\_\_\_

**Basic Health**    Good    Fair    Poor   Date of last exam? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Is child/adolescent taking any prescription medication at this time?    Yes    No

If yes, what? \_\_\_\_\_

Is child/adolescent taking any over the counter medication at this time?    Yes    No

If yes, what? \_\_\_\_\_

**Current reason for seeking counseling**

Are there any physical, emotional, or mental issues now or in the past that I need to be aware of?   Yes / No

If yes, what? \_\_\_\_\_

Has child/adolescent ever been hospitalized?   Yes / No

If yes, for what and when \_\_\_\_\_

Briefly describe the problem for which you wish your child/adolescent to have counseling:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The thing that concerns me most right now is: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Counseling would be successful if: \_\_\_\_\_

\_\_\_\_\_

***I understand that suicidal threats, homicidal threats or child abuse will be reported.  
I understand that the parent must facilitate the ability for child/adolescent to trust the therapist and will respect confidentiality when appropriate.***

Parent (s) Signature : \_\_\_\_\_

Print names : \_\_\_\_\_

Adolescent Signature: \_\_\_\_\_



## Initial Service Plan

Please check any of the reasons listed below which resulted in your coming in today:

- |                                                           |                                                                     |
|-----------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Depression or Anxiety            | <input type="checkbox"/> Difficulty with loss or death              |
| <input type="checkbox"/> Alcohol or other drug abuse      | <input type="checkbox"/> School adjustment problems                 |
| <input type="checkbox"/> Communication Difficulties       | <input type="checkbox"/> School learning difficulties               |
| <input type="checkbox"/> Harm to self or others           | <input type="checkbox"/> Low Self Esteem/social withdraw/motivation |
| <input type="checkbox"/> Abuse (physical/verbal/sexual)   | <input type="checkbox"/> General Defiance                           |
| <input type="checkbox"/> Sexual Orientation Questions     | <input type="checkbox"/> Staying Focused/Task Completion            |
| <input type="checkbox"/> Child Adjustment/Parent Conflict | <input type="checkbox"/> Eating Disorder/Obesity                    |
| <input type="checkbox"/> Divorce                          | <input type="checkbox"/> Individual Counseling                      |
| <input type="checkbox"/> Adoption                         | <input type="checkbox"/> Family Counseling                          |
| <input type="checkbox"/> _____                            | <input type="checkbox"/> _____                                      |

What event happened which made you think "I am (we are) calling a therapist?" \_\_\_\_\_

\_\_\_\_\_

Modality – who would you like to see participate in counseling?:

\_\_\_\_\_

What behaviors would you like to change? \_\_\_\_\_

\_\_\_\_\_

Patient's strengths and interests: \_\_\_\_\_

\_\_\_\_\_

Specific Goals identified (can be completed with therapist) Plan Review Date: 6 months from intake

Child                       Family                       Couple                       Individual (with or without collaterals)

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

Rachael Plyler M.S., LAMFT

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

Dr. Kimberly Bailey DBH, LMFT - 10200