



**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.)

Name	Sex	Age	Type (bio, step, etc.)	Custody?
_____	_____	_____	_____	<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 in 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	
<input type="checkbox"/> Child	<input type="checkbox"/> Family	<input type="checkbox"/> Couple	<input type="checkbox"/> Individual (with or without collaterals)
_____			
_____			

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

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

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

Brock Anderson, MFT Intern

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

Dr. Kimberly Bailey DBH, LMFT - 10200