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

Parent/Partner:_____ 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?
_____	_____	_____	_____	□ Yes □ No
_____	_____	_____	_____	□ Yes □ No
_____	_____	_____	_____	□ Yes □ 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:

- □ Depression or Anxiety
- □ Alcohol or other drug abuse
- □ Communication Difficulties
- □ Harm to self or others
- □ Abuse (physical/verbal/sexual)
- □ Sexual Orientation Questions
- □ Child Adjustment/Parent Conflict
- □ Divorce
- □ Adoption
- □ _____

- □ Difficulty with loss or death
  - □ School adjustment problems
  - □ School learning difficulties
- □ Low Self Esteem/social withdraw/motivation
- □ General Defiance
- □ Staying Focused/Task Completion
  - □ Eating Disorder/Obesity
  - □ Individual Counseling
  - □ Family Counseling
  - □ _____

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 _____

Zac Austin, MFT Intern

Supervisor Signature_____ Date _____

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