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?
				☐ 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 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:

- ☐ 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 ________________________
Gabby Cavale, MAS, LAMFT

Supervisor Signature____________________________________ Date ________________________
Dr. Kimberly Bailey DBH, LMFT - 10200