

CHILD AND ADOLESCENT CLIENT INTAKE FORM

CHILD'S NAME: _____ TODAY'S DATE: _____

CHILD'S GENDER (circle): Male/Female/Other: _____ RACE/ETHNICITY: _____

BIRTH DATE: _____ AGE: _____ GRADE: _____

CHILD'S SCHOOL OR DAYCARE _____

SPECIAL EDUCATION SERVICES, IF ANY: _____

PERSON FILLING OUT THIS FORM (circle): Mother/Father/Stepmother/Stepfather/Grandparent/ Other: _____

NAME(S) OF LEGAL GUARDIAN(S): _____

RELATIONSHIP TO CHILD: _____

PARENTS' MARITAL STATUS: _____

DESCRIBE CUSTODY ARRANGEMENT, IF APPLICABLE: _____

WHO REFERRED YOU HERE? _____ PHONE: _____

REFERRAL ADDRESS: _____ EMAIL: _____

REASON FOR VISIT

Please describe the reason for your current visit, including any difficulties that your child is having: _____

How long have these difficulties been of concern? _____; When was this problem first noticed? _____

Has your child received evaluation or treatment for the current concern or similar concerns? Yes _____; No _____

If yes, please describe previous treatment: _____

Is there any legal action currently underway in the family? Yes _____ No _____ If yes, please explain: _____

Describe any major life event that might be related to your concern (e.g. death in family, trauma, move, family conflict, natural disaster): _____

Has your child ever had previous counseling or psychotherapy? Yes ____; No ____

If Yes, by whom and when? _____

Reason for treatment? _____

If currently receiving counseling or psychotherapy elsewhere, describe reason for seeking services here: _____

Has your child ever been psychiatrically hospitalized? Yes ____ No ____; if Yes, when and where? _____

Has your child ever made a suicide attempt/gesture? Yes ____ No ____; if Yes, when (please explain): _____

Please use the scale below to indicate your child's current level of distress with the following items:

	No Concern	Some	Moderate	Urgent
Academic problems.....	0	1	2	3
Aggressive behavior	0	1	2	3
Anxiety/fears/worries.....	0	1	2	3
Attention/concentration difficulties.....	0	1	2	3
Bedwetting	0	1	2	3
Behavior problems	0	1	2	3
Change in family constellation (e.g. divorce/remarriage)...	0	1	2	3
Depression	0	1	2	3
Eating problems	0	1	2	3
Feelings over a recent loss/death	0	1	2	3
Losing contact with reality	0	1	2	3
Relationship with family	0	1	2	3
Relationship with peers	0	1	2	3
Problems with alcohol/drugs	0	1	2	3
Sexual behaviors	0	1	2	3
Sleep problems	0	1	2	3
Suicidal feelings/behaviors	0	1	2	3
Trauma/physical or sexual abuse	0	1	2	3

DEVELOPMENTAL HISTORY

Was your child adopted? Yes ____; No ____; if yes, child's age at adoption: _____

PREGNANCY: Duration of pregnancy (weeks or months): _____

During the pregnancy, did the mother experience any of the following complications (please check all that apply): ____ Suffer from illness or disease; ____ Excessive staining or blood loss; ____ Suffer from an accident; ____ Threatened miscarriage; ____ Undergo surgery; ____ Infection; ____ Take medication; ____ Toxemia; ____ Undergo x-ray studies; ____ Diabetes; ____ Smoke tobacco; ____ High blood pressure; ____ Consume alcohol; ____ Poor nutrition; ____ Use illegal drugs; ____ Other (specify): _____

DELIVERY:

Duration of Labor: _____ hours; Birth Weight: _____ lbs. _____ ozs.; Apgar Score: _____

Type of Labor (circle): Spontaneous ____; Induced ____ Type of Delivery; (please circle): Vaginal ____; Caesarean ____

Delivery Complications:

____ None; ____ Delay in breathing; ____ Cord around neck; ____ Injury to infant; ____ Hemorrhage; ____ Fetal distress;

____ Placenta problems; ____ Meconium aspiration; ____ Other (specify): _____

NEWBORN AND POST-DELIVERY PERIOD:

Total days baby was in hospital after delivery: _____; Was your baby in the NICU? Yes ____; No ____

Birth complications (check all that apply):

____ None; ____ Jaundice; ____ Respirator required; ____ Addiction; ____ Infection; ____ Resuscitation required; ____ Anemia;

____ Seizures; ____ Birth defects (specify): _____; ____ Trouble breathing; ____ Cyanosis (turned blue);

____ Intraventricular hemorrhage; ____ Other (specify): _____

INFANCY-TODDLER PERIOD:

Briefly describe your child's temperament during infancy: _____

Were any of the following present during the first few years of life (check all that apply)?

____ Colic; ____ Constantly into everything; ____ Reflux; ____ Slow or unable to adapt to changes in routine; ____ Feeding problems;

____ Excessively high or low activity level (circle one); ____ Sleeping problems; ____ Was not calmed by being held and/or stroked;

____ Frequent head banging; ____ Excessive number of accidents compared to other children; ____ Excessive restlessness;

____ Withdrawal or other problems adjusting to new people and situations; ____ Did not enjoy cuddling; ____ Variable or irregular body functions (sleep, hunger, bowel, etc.)

Were there any special problems in the growth and development of your child during the first year? Yes ____ No ____

If Yes, please describe:

Looking back, did you ever think that your child was different from other children in some significant or concerning way?

Yes ____ No ____; if so, when? _____; What did you notice that was different? _____

DEVELOPMENTAL MILESTONES:

The following is a list of infant developmental milestones. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Crawled	_____	Became toilet trained	_____
Walked alone	_____	Stayed dry at night	_____
Spoke first single words	_____	Fed self	_____
Put words together	_____	Rode tricycle	_____

Compared to other children, your child's early development was: ____ Normal; ____ Delayed; ____ Advanced

HOME INFORMATION

Mother's name: _____; Age: ____ Education: _____; Occupation: _____

Father's name: _____; Age: ____ Education: _____; Occupation: _____

Stepmother's name: _____; Age: ____ Education: _____; Occupation: _____

Stepfather's name: _____; Age: ____ Education: _____; Occupation: _____

If parents are separated or divorced, how old was the child when the separation occurred? _____

List siblings and others living in the home:

NAME	RELATIONSHIP TO CHILD	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any siblings living outside of the home:

NAME	RELATIONSHIP TO CHILD	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary language spoken at home: _____; Any other languages spoken at home? _____

What your total annual household income (from all sources) before taxes (specify sources)? _____

Provide any other important information about home: _____

FAMILY MEDICAL HISTORY

Place a check next to any illness, condition, or problem experienced by any blood relative. When you check an item, please note the relative's relationship to the child. If any problems run in the family, please specify at the end of the list.

CONDITION	RELATIONSHIP TO CHILD
____ Alcoholism.....	_____ (specify): _____
____ Antisocial (criminal) behavior.....	_____ (specify): _____
____ Autism Spectrum Disorder	_____ (specify): _____
____ Asperger's Disorder.....	_____ (specify): _____
____ Bipolar (Manic-depressive) Disorder	_____ (specify): _____
____ Depression	_____ (specify): _____
____ Drug addiction or drug problems.....	_____ (specify): _____
____ Headaches (e.g. migraine)	_____ (specify): _____
____ ADHD (Hyperactivity / Attention problems).....	_____ (specify): _____
____ Language disorder or delay	_____ (specify): _____
____ Learning problems.....	_____ (specify): _____
____ Developmental Delay / Mental Retardation	_____ (specify): _____
____ Tic or Movement Disorders.....	_____ (specify): _____
____ Nervous or mental problems.....	_____ (specify): _____

_____ Schizophrenia (specify): _____
 _____ Seizures, Epilepsy, or convulsions (specify): _____
 _____ Sexual / physical abuse..... (specify): _____
 _____ Suicide or suicide attempt (specify): _____
 _____ Other (specify) (specify): _____

CHILD'S MEDICAL HISTORY

Pediatrician's name: _____; Address: _____
 Phone: _____ Fax: _____; Email: _____

Has your child has ever been treated with medication other than for colds and minor infections? _____ Yes; _____ No
 If Yes, please complete medication information below. Place a check under "Current?" for those medications the child is currently taking.

If yes, list medication(s), current dosage(s), reason prescribed?, and prescribing doctor(s):

Medication and Dosage	When & Reason it was Prescribed?	Prescribing Doctor	Current?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you get all of your child's prescription medicines filled at the same pharmacy? _____ Yes; _____ No

If No, describe reason and list pharmacies (including online sites) where you get your child's medications:

Has your child ever had any adverse or negative side effects related to any medication(s) taken? _____ Yes; _____ No

If Yes, list medication(s) and describe side effects: _____

Is your child allergic to any medication(s)? _____ Yes; _____ No

If Yes, describe: _____

Is your child currently taking any supplements, vitamins, or herbal remedies? _____ Yes; _____ No

If Yes, list name(s), current dosage(s), how long, and reason for taking:

Names and Dosages	How Long Taken	Reason(s) for Taking?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your child allergic to any supplement(s)? _____ Yes _____ No; if Yes, describe: _____

Has your child ever suffered from a head injury that caused confusion or loss of consciousness? _____ Yes; _____ No

Place a check next to any illness or condition that your child has/had. When you check an item, also note your child's approximate age at the time of the illness.

Illness or condition	Age or Dates	Illness or condition	Age or Dates
_____ AIDS or HIV+	_____	_____ Cystic Fibrosis	_____
_____ Allergies	_____	_____ Dazed/Unconscious	_____
_____ Anemia	_____	_____ Dementia	_____
_____ Aneurysm	_____	_____ Diabetes	_____

Illness or condition	Age or Dates	Illness or condition	Age or Dates
<input type="checkbox"/> Anoxia	_____	<input type="checkbox"/> Dysarthria	_____
<input type="checkbox"/> Arteriovenous Malformation	_____	<input type="checkbox"/> Dyspraxia/Apraxia	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Ear Infection (PE Tubes)	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Other Ear Problems	_____
<input type="checkbox"/> Ataxia	_____	<input type="checkbox"/> Eczema/Hives	_____
<input type="checkbox"/> Auto Accident	_____	<input type="checkbox"/> Encephalitis	_____
<input type="checkbox"/> Back Pains or Problems	_____	<input type="checkbox"/> Epilepsy/Seizures	_____
<input type="checkbox"/> Bleeding Problems	_____	<input type="checkbox"/> Fainting Spells	_____
<input type="checkbox"/> Blood Disorders	_____	<input type="checkbox"/> Fetal Alcohol Syndrome	_____
<input type="checkbox"/> Bone or Joint Disease	_____	<input type="checkbox"/> Fever (if very high or prolonged)	_____
<input type="checkbox"/> Broken Bones	_____	<input type="checkbox"/> Guillain-Barre	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Head Injury	_____
<input type="checkbox"/> Chorea	_____	<input type="checkbox"/> Headaches	_____
<input type="checkbox"/> Coma	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Lead Poisoning	_____	<input type="checkbox"/> Scarlet Fever	_____
<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Sensory Losses	_____
<input type="checkbox"/> Herpes	_____	<input type="checkbox"/> Sexual Molestation	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Sexually Transmitted Disease	_____
<input type="checkbox"/> Jaundice	_____	<input type="checkbox"/> Speech/Language Problems	_____
<input type="checkbox"/> Leukemia	_____	<input type="checkbox"/> Spells (_____)	_____
<input type="checkbox"/> Malnutrition	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Sunstroke/Heat Exhaustion	_____
<input type="checkbox"/> Muscular Disease	_____	<input type="checkbox"/> Thyroid Problems	_____
<input type="checkbox"/> Pain Problems	_____	<input type="checkbox"/> Trauma (_____)	_____
<input type="checkbox"/> Paralysis	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Pituitary Disorder	_____	<input type="checkbox"/> Tumor	_____
<input type="checkbox"/> Pneumonia	_____	<input type="checkbox"/> Visual Problems	_____
<input type="checkbox"/> Poisoning	_____	<input type="checkbox"/> Whooping Cough/Pertussis	_____
<input type="checkbox"/> Poliomyelitis	_____	<input type="checkbox"/> Other Medical Problem(s) _____	_____
<input type="checkbox"/> Rheumatic Fever	_____		_____
<input type="checkbox"/> Chronic Fatigue	_____		_____

Indicate if you have undergone any of the following medical tests (please check and give age):

<input type="checkbox"/> Electroencephalogram (EEG)	_____	<input type="checkbox"/> BEAM Scan	_____
<input type="checkbox"/> Skull X-Ray	_____	<input type="checkbox"/> Evoked Potentials	_____
<input type="checkbox"/> CT/CAT Scan	_____	<input type="checkbox"/> Ophthalmological (Vision)	_____
<input type="checkbox"/> MRI Scan	_____	<input type="checkbox"/> Audiological (Hearing) Evaluation	_____

EDUCATIONAL HISTORY

SCHOOL: _____ CURRENT GRADE: _____ Grades repeated (if any): _____

SCHOOL PHONE: _____ PRINCIPAL: _____

LEAD TEACHER: _____

SPECIAL EDUCATION CLASSIFICATION (if any): _____

Describe any academic or behavioral concerns at school: _____

Previous school placements / Experiences: _____

List or estimate current report card grades: _____

Describe private services (speech / language, occupational therapy): _____

What discipline techniques are effective in your home? _____

What discipline techniques are usually not effective? _____

Center for Emotion

