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Child & Adolescent Assessment

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CHILD INTAKE FORM

Child's Full Name: _____

Date of Birth: _____ Gender: ☐Male ☐Female

Referred by (Name/Agency): _____

Primary Care Physician: _____ Phone: _____

School: _____ Grade: _____

Parent #1 Name: _____

Parent #2 Name: _____

Child's Address: _____

_____

Home Phone: _____ day/evening OK to leave msg? ☐Yes ☐No

Work Phone: _____ day/evening OK to leave msg? ☐Yes ☐No

Cell Phone: _____ day/evening OK to leave msg? ☐Yes ☐No

Child lives with:

☐ Both Parents ☐ Mother only ☐ Father only

☐ Both Parents but separate houses ☐ Parent and Step Parent ☐ Other: _____

List names and ages of all individuals, including parents, residing in the child's primary home:

Name: _____ Age: ___ Relationship to client: _____

Name: _____ Age: ___ Relationship to client: _____

Name: _____ Age: ___ Relationship to client: _____

Name: _____ Age: ___ Relationship to client: _____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____ Phone #: _____

Ins. Co. Address: _____

Subscriber's Name:_____ Subscriber Birthdate: _____

ID #: _____ Group/Plan #: _____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____ Phone #: _____

Ins. Co. Address: _____

Subscriber's Name:_____ Subscriber Birthdate: _____

ID #: _____ Group/Plan #: _____

REASON FOR VISIT

Briefly describe your primary concerns and why you have brought your child to the office:

_____

_____

FAMILY SITUATION

Relationship Status of Parents:

☐Cohabitating ☐Married ☐Separated ☐ Divorced ☐Widowed ☐Remarried (circle Mother, Father, or Both)

Parent #1 Ethnic Background: _____

Parent #2 Ethnic Background: _____

Parent #1 Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

Parent #2 Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

FAMILY HISTORY

List any ***immediate or extended family members*** with a history of concerns in the areas listed below. Please indicate their relationship to the child and provide more detailed information, such as specific diagnosis. There is additional space on the final page if needed.

Chronic Physical Health Issues

Past: _____

_____

Present: _____

_____

Mental Health Concerns

Past: _____

_____

Present: _____

_____

Learning and/or Attention Concerns

Past: _____

_____

Present: _____

_____

Developmental Delay and/or Autism Spectrum Disorders

Past: _____

_____

Present: _____

_____

Drug/Alcohol Dependence or Abuse

Past: _____

_____

Present: _____

_____

Physical/Sexual Abuse and/or Neglect

Past: _____

_____

Present: _____

_____

Domestic Violence

Past: _____

_____

Present: _____

_____

CHILD'S MEDICAL HISTORY

How is your child's general health? ☐ Excellent ☐ Good ☐ Fair ☐Poor

When was your child's last comprehensive medical evaluation? _____

List any serious illnesses for which your child required hospitalization or surgical operation:

Illness: _____ Year: ___ Doctor/Hospital: _____

Illness: _____ Year: ___ Doctor/Hospital: _____

Illness: _____ Year: ___ Doctor/Hospital: _____

Is your child currently taking any medications/supplements/vitamins? ☐Yes ☐No

Medication:_____ Dosage: _____ Date Started: _____ Prescriber: _____

Medication:_____ Dosage: _____ Date Started: _____ Prescriber: _____

Medication:_____ Dosage: _____ Date Started: _____ Prescriber: _____

Supplement/Vitamin:_____ Dosage: _____ Date Started: _____

Supplement/Vitamin:_____ Dosage: _____ Date Started: _____

List previous or current counseling, substance abuse services, psychiatric services, hospitalizations for mental health reasons, or psychological, speech/language, or occupational therapy assessment or services.

Service: _____ Year Started: _____ Currently receiving services? ☐Yes ☐No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? ☐Yes ☐No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? ☐Yes ☐No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? ☐Yes ☐No

Doctor/Therapist/Agency: _____

Please check whether your child currently has or has ever had any of the following:

Attention/Educational Issues	**Developmental/Medical Issues**	**Emotional/Behavioral Issues**
_ Inattention	_ Speech delay/problems	_ Verbal aggression/defiance
_ Organizational difficulties	_ Fine/Gross motor delay	_ Difficulty managing anger
_ Academic delays/concerns	_ Hearing problems	_ Physically aggressive
_ Memory concerns	_ Vision problems	_ Sexualized behavior
_ Peer conflict/bullying	_ Bedwetting/bowel problems	_ Low self-esteem
	_ Head injury/concussion	_ Depressed mood/withdrawn
Stresses/Trauma	_ Frequent stomachaches	_ Mood swings
_ Family issues/conflict	_ Frequent headaches	_ Anxiety
_ Witness to domestic violence	_ Epilepsy or seizures	_ Ritualistic/Repetitive behaviors
_ Multiple moves	_ Sleeping problems	_ Irritability
_ Deaths or losses	_ Self-injurious behavior	_ Panic Attacks
_ Chronic illness in family		_ Disturbing thoughts
_ History of sexual abuse		_ Feelings of hopelessness
_ History of physical abuse		_ Extreme fears
_ History of emotional abuse		_ Running away
_ History of neglect		_ Suicidal thoughts/attempts
_ Legal issues		_ Drug/alcohol use

Thank you for providing this information.

Additional comments/family history: