CONFIDENTIAL

CHILD AND ADOLESCENT INTAKE FORM

To be completed by parent or guardian requesting services for a minor child. This information will help your counselor understand your child. All communications with your therapist will be kept confidential to the full extent of Texas Law.

DATE_____

Child's Name_____ Date of Birth_____ Age_____

Gender_____ Race_____ Grade_____

Child's Address_____ Phone _____

Child lives with:_____

If child does not live with biological parent(s), please explain circumstances:_____

_____

Describe the documentation that gives you primary custody_____

*****Please provide copy of the official documentation of your custody*****

PRIMARY CAREGIVER OF CLIENT (Legal Custody Holder)

Name_____ Relationship to Client_____

Age_____ Race_____ Marital Status_____ Education completed_____

Employer_____Occupation_____

Can you be contacted at work by phone? Work Phone:_____ Ext._____

Email_____

Religious Denomination_____Church_____

Describe any physical problems you have that require medication or physical care:_____

_____

Are you currently receiving medical treatment? Physician:_____

Medication(s) currently using:_____

Previous Counseling/Therapy? If yes, when?_____

With whom and for how long?_____

JOINT OR SECONDARY CUSTODY HOLDER OF CLIENT

Name_____ Relationship to Client_____

Age_____ Race_____ Marital Status_____ Education completed_____

Employer_____Occupation_____Hrs/wk_____

Can you be contacted at work by phone? Work Phone:_____ Ext._____

Religious Denomination_____Church_____

Describe any physical problems you have that require medication or physical care:_____

_____

Are you currently receiving medical treatment? Physician:_____

Medication(s) currently using:_____

Previous Counseling/Therapy? If yes, when?_____

With whom and for how long?_____

FAMILY MEMBERS

List all people now living in the household.

Name	Relationship to child	Age	Highest Grade Completed	Occupation

List all others who have lived in the household during the child's lifetime.

Name	Relationship to child	Age	Highest Grade Completed	Occupation

List all other extended family members by their relation to the child:

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

__ Intellectual Disabilities __ ADD/ADHD __Autism Spectrum Disorder __Schizophrenia __Bipolar __Depression __Anxiety __Alcohol abuse __Drug abuse __Suicide/Suicide Attempt __ Victimization (child abuse, domestic violence, assault) ___Other

If so, please explain _____

LIVING ARRANGEMENTS

Number of moves in child's life_____

Places	Dates	Reason for move

Does the child share a room with anyone? If yes, with whom? _____

Was the child ever placed, boarded or lived away from the family? If yes, explain _____

_____

_____

What are the major family stressors at the present time, if any? _____

_____

What are the sources of family income? _____

CLIENT CONCERNS

Please choose a number (from 1-10) that reflects the extent of your concern (for your child) in each area listed below. You may add written comments beside areas of concern.

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

1._____ Anger/Temper
2._____ Depression
3._____ Divorce/Separation of Parents
4._____ Adjustment to Parent's Remarriage
5._____ School Performance
6._____ Family Problems
7._____ Fearfulness
8._____ Physical Problems
9._____ Problems with Social Relationships
10._____ Problems Sleeping
11._____ Nightmares
12._____ Sexual Concerns
13._____ Religious/Spiritual Concerns
14._____ Talk of suicide
15._____ Unhappy Most of the Time
16._____ Use of Alcohol
17._____ Use of Drugs
18._____ Work
19._____ Worry
20._____ Self-esteem
21._____ Poor Appetite
22._____ Overeating
23._____ Bedwetting
24._____ Soiling
25._____ Cruelty to Animals
26._____ Fire Setting

Other problem(s):_____

_____

Have there been any previous psychological, psychiatric, neurological or E.E.G. evaluations? __Yes __No

Has child previously been in counseling? If yes, please list name of counselor, number, and dates of contact

_____

_____

What prompted counseling now?_____

_____

_____

How long has this been an issue?_____

What have you done to try to resolve this issue?_____

_____

_____

MEDICAL HISTORY

Were there any complications surrounding the child's birth? __Yes __No

If yes, please explain_____

Has the child ever been hospitalized? __Yes __No

If yes, please explain_____

List any current medical problems:_____

_____

Is child currently taking any prescription drugs? __Yes __No

If yes, please list medication, dosage, and reason for taking:_____

_____

ACADEMIC INFORMATION

Name of school_____ Grade_____ Teacher_____

Describe any difficulties in learning at school_____

How does your child get along at school? _____

Does your child attend school on a regular basis? __Yes __No

Has your child ever been suspended or expelled? __Yes __No

How many friends does your child have in school?_____

Describe what your child likes to do for fun, special interests, hobbies, etc._____

_____

Anything else you think would be important for the counselor to know: _____

_____

_____

_____

Custodial Parent/Guardian_____Date_____