Collaborative Counseling

Child/Adolescent Intake Form

Client's name: _____ Date of birth: _____

Form completed by (if someone other than the client): _____ Age: _____

Best number to reach you at: _____ Circle: Home Cell Work

Emergency contact: _____ Phone: _____

Please state briefly why you are seeking treatment at this time: _____

_____

Do you have a Primary Care Physician, Psychiatrist and/or Pediatrician? Circle: YES NO

Name of Doctor(s): _____

Would you like your therapist to coordinate care with their Physician? Circle: YES NO

Please check any of the following characteristics or behaviors typical of your child/adolescent:

	Physical Aggression		Blames Others
	Verbal Anger		Careless/Reckless
	Anxious		Impulsive
	Mind racing		Impatience
	Avoidance		Uncooperative
	Day dreaming		Defiant/Oppositional
	Fear/Panic		Legal problems
	Irritability		Lying
	Crying Spells		Obsessions/Rituals
	Depressed mood		Inattention
	Difficulty with change		Rigid Thinking
	Lack of motivation		Nightmares
	Withdrawn		Sleep problems (wakeful/falling)
	Worthlessness/Guilt		Appetite Disturbance
	Physical complaints		Weight loss/Weight gain
	Helpless Feelings		Hallucinations
	Moody/Mood swings		Substance Use Problems
	Distrusts Others		Cutting/Self Injury
	Relational Problems		Homicidal Thoughts/Plans
	Social Deficits		Suicidal Thoughts/Plans
	Destroys Property		Difficulty Separating from Caregiver
	Temper Tantrums		Other:

How long have symptoms been present for? _____

Client Past Mental Health and/or CD Treatment History

Prior Outpatient Treatment

Dates Clinic Therapist Diagnosis/Reason for Treatment

_____ _____ _____ _____

_____ _____ _____ _____

Inpatient Hospitalization for Mental Health Issues

Dates Clinic Therapist Diagnosis/Reason for Hospitalization

_____ _____ _____ _____

_____ _____ _____ _____

CD Assessment/Treatment (Date/Place): _____

_____

Number of times in Treatment for CD Issues: _____

Family History

What is the current family situation*?* Married: _____ Separated/Divorced: _____ Other: _____

Custody/Placement Agreement: _____

Is there any information about the parents' relationship that may be beneficial to therapy? ____Yes _____No

If yes, please describe: _____

Have there been any significant changes or events in your child/adolescent's life? (e.g. family, move, fire)

____Yes _____No If yes, describe: _____

_____

People living in household with client

Name	Relationship (e.g. sibling, parent, cousin)	Age	List any mental health or substance use concerns and anything notable about your relationship with them

Client's Family Information

Parents	Age	Relationship History

Siblings	Age	Relationship History

Is there any family history of mental health concerns and/or substance abuse? _____Yes _____No
If yes, please complete the following:

Family member	Diagnosis/Issue(s)	Treatment received	Other information

Have you had any divorce (s), major break ups with a significant other: ___Yes___No

If yes please describe:_____

Have you moved multiple times: ___Yes ___No If yes please describe: _____

_____

Other Significant Relationships

Name	Relationship (i.e. significant other, friend, cousin, etc…)	Age	List any mental health or substance use concerns and anything notable about your relationship with them

Who handles responsibility for the child/adolescent in these areas (check all that apply)?

	Parent name:	Parent name:	Other:
School			
Health			
Sports/Activities			
Behavior Problems			

Cultural/Ethnic
Does your child/adolescent and/or family belong to any cultural or ethnic group? _____Yes _____No

If yes, please describe: _____

Are you experiencing any cultural or ethnicity-related problems? ___Yes ___No If yes, please describe:

_____

Anything else you would like to note regarding culture and ethnicity? _____

_____

Religious/Spirituality
Does your child/adolescent and/or family belong to any religious and/or spiritual group? ____Yes _____No

If yes, please describe: _____

Are you experiencing any religion/spirituality-related problems? ___Yes ___No If yes, please describe:

_____

How important is religion/spirituality to your child/adolescent? _____

Anything else you would like to note regarding religion/spirituality? _____

_____

Child/Adolescent's Life History

Pregnancy/Birth
Was the pregnancy planned? _____Yes _____No

Child/adolescent was number _____ of _____ total children.

How long was the pregnancy? _____ Did the mother smoke during pregnancy? _____Yes _____No

Did the mother use any alcohol or drugs during pregnancy? _____Yes _____No If yes, please describe: ___

_____

Were there any emotional concerns or notable events for the mother during pregnancy? _____Yes _____No

If yes, describe: _____

Were there any physical concerns or problems for the mother or child during pregnancy? ___Yes ____No

If yes, describe: _____

Were there any emotional or physical concerns for the mother or baby after pregnancy? ____Yes ____No

If yes, describe: _____

Anything else you would like to note? _____

_____

Infancy/Toddlerhood
Was there anything notable about life circumstances for the child and/or family? _____

_____

Please check any that applied to your child/adolescent as an infant and/or toddler:

	Cried often
	Cried rarely
	Easygoing
	Irritable
	Cuddly

	Difficulties with feeding
	Overactive
	Didn't like physical contact

	Sensory sensitivity (e.g. sounds, lights)
	Sleeping problems
	Other:

Any food allergies ____Yes ____No If yes: _____

Abuse/ Trauma History
Has the client been a victim or at risk for emotional, physical or sexual abuse? ___Yes ___No

Describe: _____

Other trauma/losses: _____

Developmental history
Were there any issues that affected the client's development (e.g. medical, nutrition, etc...)? ___Yes ____No

If yes, please describe: _____

_____

_____

Did your child/adolescent demonstrate any delays in the following areas? (Please check any that apply):

	Smiling or facial expressions
	Eye contact
	Sat on their own

	Spoke words
	Spoke sentences
	Potty training
	Walking (took first steps)

	Other:
	Other:

Medical History and Physical Health

List any past health concerns, conditions or procedures: _____

_____

List any current health concerns or conditions: _____

_____

Please list any allergies: _____

List any current medications (both prescribed and over-the-counter):

Medication name	Dosage	Dates taken	Purpose	Side effects	Benefits (e.g. Is it working?)

Please list your child/adolescent's most recent examinations:

	Date	Reason	Results
Physical exam			
Doctor's visit			
Vision exam			
Hearing exam			
Dentist visit			
Surgery			
Other:			

Have there been any recent changes in the following? (Check all that apply)

	Sleep		Mood/Disposition		Behavior
	Appetite		Weight gain or loss		Other:

Describe any changes you have noticed or that your child/adolescent has reported: _____

_____

Legal History

Do you have any history of legal issues? ___Yes _____No If yes, please describe: _____

_____

Do you have any current or pending legal issues? ___Yes _____No If yes, please describe: _____

_____

Educational History

Current School: _____ Grade: _____ Teacher: _____

Are there any academic concerns? _____Yes _____No If yes: _____

Does your child/adolescent have any specialized learning needs? _____Yes _____No If yes: _____

_____

Has your child/adolescent undergone a psychological evaluation? ____Yes ____No If yes: _____

Has your child/adolescent ever been held back? _____Yes _____No If yes: _____

In general, how does your child/adolescent feel about school? _____

Social/Peer Relationships
How would you describe your child/adolescent? (Check all that apply)

	Leader
	Follower
	Outgoing
	Shy/Reserved

	Difficulty making friends
	Bossy
	Well liked by peers

	Bullies others
	Gets bullied
	Other:

Any additional concerns or notes regarding your child/adolescent's social skills or relationships: _____

_____

_____

Leisure/Recreational Activities
Describe your child/adolescent's special areas of interest, hobbies and activities: _____

_____

Chemical Use History (to be completed by child/adolescent)
Does your child use or have any problems with drugs, nicotine and/or alcohol? _____Yes _____No If yes, complete:

Substance	Method and amount used	Frequency of use	Age of first use	Last use/most recent date of use

The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)	**YES**	**NO**
1. Have you felt you ought to cut down on your drinking or drug use?		
2. Have people annoyed you by criticizing your drinking or drug use?		
3. Have you felt bad or guilty about your drinking or drug use?		
4. Have you ever had a drink or used drugs first in the morning to steady your nerves or to get rid of a hangover (eye-opener)?		
Yes = 1. No = 0. 2/4 or greater = positive CAGE, further evaluation is indicated.	Score: ____/4	

What is/are your substance(s) of preference: _____

What are your reasons for using? (e.g. addicted, build confidence, escape, social, medicate, etc…) _____

_____

Describe when and where you typically use substances: _____

_____

How has your substance use affected your life? _____

_____

Describe any changes in your substance use: _____

_____

Do you believe your substance use is a problem? _____ Yes _____ No Describe: _____

_____

Does anyone support your in stopping or limiting your substance use? _____ Yes _____ No

If yes, describe: _____

Anything else you want to report? _____

Other Questions for Therapy

Any additional information you think would assist in our understanding of your situation or concerns?

_____

_____

What are your goals for therapy? _____

_____

What family involvement in therapy would you like to see? _____

_____

What do you consider to be your child/adolescent's strengths? _____

_____

What do you consider to be your child/adolescent's weaknesses? _____

_____

For Staff Use Only

Therapist's comments: _____

_____

_____

Therapist's signature: _____ Date: _____

Physical exam: _____ Required _____ Not Required