CHILD/ADOLESCENT INTAKE FORM

Restoration Counseling
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Client Information

Child's Name: _____ Date of birth: _____Age: _____

Was your child referred to counseling? ☐ Yes ☐ No If so, by whom?

_____

Parent/Guardian: _____

Parent/Guardian's Address: _____

City: _____State: _____ Zip: _____

May I send correspondence to this address if needed? ☐ Yes ☐ No

Best phone number to reach you at: (_____) _____ ☐ Home ☐ Work ☐ Cell

May I contact/leave you a message at this number? ☐ Yes ☐ No

Primary Email Address: _____

Is the parent/guardian employed? ☐ Yes ☐ No If so, by whom? _____

Does the child live with both biological parents**?** ☐ Yes ☐ No

**If Parents are Divorced (a copy of divorce decree/custody agreement is required):*

Who is the primary custodian of the child? _____

Who is the child's non-custodial parent? _____

Is there any information about this relationship that may be beneficial to therapy? ☐ Yes ☐ No

If yes, please describe: _____

_____

Current Concerns

What is the concern or issue that brings your child to counseling at this time?

_____

_____

Have there been any significant changes or events in the past year (e.g., divorce, death of a loved one, move) that have impacted your child's life? ☐ Yes ☐ No *If yes, please describe:*

_____

_____

Family Environment

Please identify people living in the household with child.

Relationship to child	Name	Gender	Age	Quality of Relationship
_____		☐ F ☐ M	_____	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	_____	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	_____	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	_____	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	_____	☐ Poor ☐ Average ☐ Good
_____		☐ F ☐ M	_____	☐ Poor ☐ Average ☐ Good

Medical/Physical Health

Who is your child's doctor?_____Location: _____

Is your child under the care of a psychiatrist? ☐ Yes, _____ ☐ No

Has your child had a serious illness, a surgery, or any other significant medical condition/procedure in the past 12 months? ☐ Yes ☐ No

-*If yes, please explain:* _____

Are there any other health concerns or conditions that I need to be aware of? ☐ Yes ☐ No

-*If yes, please explain:*_____

Is your child currently taking any prescription medications? ☐ Yes ☐ No

If yes, please complete the following information:

Medication	Dosage	How Often	Treats	Benefits (How is it working?)

Behaviors/Feelings

Please check any of the following that describe your child during the past 3 months:

☐ Poor attention/concentration	☐ Angry/resentful	☐ Grief/crying spells
☐ Temper outbursts	☐ Reckless sexual activity	☐ Sleep disturbances
☐ Aggressive towards people	☐ Deliberately sets fires	☐ Hallucinations
☐ Anxiety/Panic attacks	☐ Stress	☐ Self-esteem issues
☐ Withdrawn/ isolative	☐ Moody/irritable	☐ Hyperactivity
☐ Physically cruel towards animals	☐ Binge eating/under eating	☐ Blames others for own mistakes
☐ Hopelessness	☐ Low motivation	☐Fears/phobias/worrisome
☐ Poor impulse control	☐ Depression	☐ Argues with adults
☐ Obsessive thoughts	☐ Compulsive behaviors	☐ Difficulty trusting
☐ Steals	☐ Low energy/fatigue	☐ Destroys property
☐ Headaches	☐ Bullies/threatens	☐ Pornography Use
☐ Internet Addiction	☐ Body Image Issues	☐ Other concerns:

Mental Health History *(Please check any that may apply):*

Client History

Please select all that apply to your child's history:

☐ Physical Abuse	Age:_____ Was this reported? _____
☐ Sexual Abuse	Age:_____ Was this reported? _____
☐ Emotional Abuse	Age:_____ Was this reported? _____
☐ Neglect	Age:_____ Was this reported? _____
☐ Drug Abuse	Age:_____
☐ Alcoholism	Age:_____
☐ Domestic Violence	Age:_____
☐ Psychiatric Difficulties	Age:_____
☐ Criminal Difficulties	Age:_____
☐ Other: _____	Age:_____

Family History

Please select all that apply to your child's family history (immediate and extended family):

☐ Physical Abuse	Family Member / Age: _____
☐ Sexual Abuse	Family Member / Age: _____
☐ Emotional Abuse	Family Member / Age: _____
☐ Neglect	Family Member / Age: _____
☐ Drug Abuse	Family Member / Age: _____
☐ Alcoholism	Family Member / Age: _____
☐ Domestic Violence	Family Member / Age: _____
☐ Psychiatric Difficulties	Family Member / Age: _____
☐ Criminal Difficulties	Family Member / Age: _____
☐ Other: _____	Family Member / Age: _____

Counseling/Mental Health

 My child has previously received counseling/psychotherapy services. Please provide the name of the therapist, duration of treatment, diagnosis, and results of treatment.

_____

_____

 My child has been hospitalized for a mental illness. Please provide the name of the facility, date of service, duration of stay, diagnosis, and purpose of treatment.

_____

_____

 There has been a previous suicide attempt(s) made by my child. Please identify the number of attempts made and provide information about the incident(s) here:

Year	Age	Method	Location of Attempt	Medical Services Required

During the past six months has your child expressed thoughts about suicide (verbally, in writing, to others)? ☐ **Yes** ☐ **No** ☐ **I don't know**

Please list any other important information related to suicide concerns here:

_____

_____

Is your child acting out physically towards him/herself or towards others? ☐ Yes ☐ No

If so, please identify the physical behavior(s):

 Punching Kicking Choking Cutting Other:

Is your child acting out sexually and/or viewing pornography? ☐ Yes ☐ No

If so, please explain:

_____

Educational History

What is the name of the school your child currently attends? _____

In what city is the school located in? _____What grade is your child in? _____

Does your child have any specific learning needs, or participate in special education services?

☐ Yes ☐ No

If so, please describe services received and identified disability (ies):

_____

Does your child have a history of discipline problems at school? ☐ Yes ☐ No

-If so, when did they begin? _____

Has your child been mandated to an alternative disciplinary educational program this school year or been suspended from school for a campus offense? ☐ Yes ☐ No

-If so, please explain: _____

Does your child frequently miss school for any reason? ☐ Yes ☐ No

-If so, please explain: _____

Overall, how would you describe your child's educational experiences?

_____

Overall, how would you describe your child's academic performance?

_____

Social/Peer Relationships

How would you describe your child? *(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's social skills or peer relationships?

☐ Yes ☐ No *If yes, please explain:* _____

Cultural/Ethnicity

Does your child and/or family identify with a particular cultural or ethnic group?

☐ Yes ☐ No *If yes, please identify:* _____

Is your child experiencing any problems related to assimilation and/or acculturation?

☐ Yes ☐ No *If yes, please describe:* _____

_____

Is there anything else you would like me to note regarding culture and ethnicity? If so, please describe: _____

Religious/Spirituality

Does your child and/or family belong to any religious and/or spiritual group?

☐ Yes ☐ No *If yes, please describe:* _____

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

Is your child experiencing any problems related to faith, spirituality, or religion

☐ Yes ☐ No *If yes, please describe:* _____

Do you wish for me to integrate Christian faith, religious/spiritual values and principles into the therapy sessions? ☐ Yes ☐ No

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

If so, please describe: _____

Substance Use History

Has your child had any problems with either drugs or alcohol, currently or in the past?

☐Yes ☐ No *If yes, please explain:*

_____

_____

Has your child ever been through an alcohol or chemical dependency treatment program (inpatient or outpatient)? ☐ Yes ☐ No

If so, provide the name of the facility, dates of service, duration of stay if inpatient, and results of treatment: _____

_____

Does your child use tobacco? ☐ Yes ☐ No

If so, please describe the type and frequency (e.g., cigarettes, vape, cigars, etc.):

_____

_____

Legal History

Does your child have any history of legal issues? ☐ Yes ☐ No

If yes, please describe: _____

Does your child have any pending legal issue or an upcoming court date? ☐ Yes ☐ No

If yes, please describe: _____

Leisure/Recreational Activities

Are there any special interests, hobbies, or activities that your child likes to participate in?

If so, please describe: _____

_____

_____

Additional Comments

If there is anything else you would like me to know or be aware of, please describe here:

_____

_____

_____

_____