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:

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

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

 One of my family members (blood relative) has experienced emotional problems, nervous problems, depression, or other stress conditions. If so, please list the family member(s) and briefly describe the problem: _____

_____

 One of my family members (blood relative) has had problems with alcohol. If so, please list the family member(s) and briefly describe the problem.

_____

_____

 One of my family members (blood relative) has had problems with drugs. If so, please list the family member(s) and briefly describe the problem.

_____

_____

 One of my family members has attempted or committed suicide. If so, please list the family member, year of incident, and method.

_____

_____

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
☐ 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
☐ Other concerns:

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

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:

Please explain: _____

Is your child acting out sexually? ☐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 complete the following information about your child's substance use (not prescribed) to the best of your knowledge.

Substance	Has used in the past?	Uses now?	How Often?	How much each time?	Age when first used
Alcohol					
Marijuana					
Synthetic Marijuana (kush, K2, etc.)					
Amphetamines (meth, etc.)					
Cocaine					
Hallucinogens (LSD, mushrooms, etc.)					
Xanax					
Muscle Relaxers					
Inhalants					
Tobacco					
Other:					

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: _____

_____

Is your child currently in a 12-step program for addictions treatment? ☐Yes ☐No

Has your child participated in a 12-step program in the past? ☐Yes ☐No

If yes to either question above, what was the name of the program? _____

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:

_____

_____

_____

_____