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CHILD AND ADOLESCENT CLIENT
INTAKE INFORMATION

BASIC INFORMATION

CHILD'S NAME: _____ **TODAY'S DATE:** _____ **PATIENT #:**_____

GENDER (select): Male ☐ Female ☐ **RACE (select):** ☐ White ☐ Black ☐ Other: _____

BIRTH DATE: _____ **CHILD'S AGE:** _____ years

LEGAL GUARDIAN(s): _____ **RELATION TO CHILD:** _____

HOME ADDRESS: _____ **HOME PHONE:** _____

CITY:_____ **STATE:** _____ **ZIP:** _____ **BUSINESS PHONE:** _____

PERSON(s) OR AGENCY POSSESSING CUSTODY OF CHILD: _____

CHILD'S SCHOOL/DAYCARE: _____ **PARISH:** _____ **GRADE:** _____

ADDRESS: _____ **PHONE:** _____

SPECIAL EDUCATION PLACEMENT AND SERVICES (if any): _____

PERSONS FILLING OUT THIS FORM (circle) MOTHER FATHER STEPMOTHER STEPFATHER OTHER: _____

WHO REFERRED YOU HERE: _____ **TITLE:** _____

ADDRESS: _____ **PHONE:** _____

REASON FOR REFERRAL

Briefly describe your child's current difficulties:

_____

_____

_____

_____

_____

_____

How long has this problem been of concern to you? _____ **When was this problem first noticed?** _____

Have any other family members had similar problems? ☐ **Yes** ☐ **No** **If yes, whom?** _____

Is any legal action currently underway in this family? ☐ **Yes** ☐ **No**

If yes, explain: _____

_____

PSYCHIATRIC HISTORY

Has your child received an evaluation or treatment for the current problem or similar problems? ☐ Yes ☐ No

If yes, when and with whom? _____

If currently, list address and phone number: _____

Describe any major event(s) that might be related to the problem (e.g., death, divorce, sexual abuse, etc.):

_____

_____

FAMILY PSYCHIATRIC HISTORY

Many psychiatric illnesses have a strong genetic component and are passed down from parents to their children. Place a check next to any illness, condition, or problem experienced by your child and/or any blood relative(s). When you check an item, please note the member's relationship to child. If any other problems run in the family, please write them down at the end of the list.

	CONDITION	RELATIONSHIP TO CHILD
☐	Adjustment Disorder	_____
☐	Agoraphobia	_____
☐	Alcohol abuse/dependence	_____
☐	Antisocial (criminal) behavior	_____
☐	Anxiety Disorder	_____
☐	Asperger's Disorder	_____
☐	Attention Deficit/Hyperactivity Disorder	_____
☐	Autism	_____
☐	Bipolar Disorder (Manic-depressive)	_____
☐	Communication Disorder	_____
☐	Conduct Disorder	_____
☐	Dementia	_____
☐	Depression	_____
☐	Drug Addiction or drug problem	_____
☐	Eating Disorder	_____
☐	Elimination Disorder (Encopresis/Enuresis)	_____
☐	Learning Problems	_____
☐	Mental Retardation	_____
☐	Motor Skills Disorder	_____
☐	Posttraumatic Stress Disorder	_____
☐	Tic Disorder (Motor and/or Vocal)	_____
☐	"Nervous or mental problems"	_____
☐	Obsessive-Compulsive Disorder	_____
☐	Oppositional Defiant Disorder	_____
☐	Personality Disorder	_____
☐	Schizophrenia	_____
☐	Sexual/physical abuse	_____
☐	Specific Phobia	_____
☐	Suicide or suicide attempt	_____
☐	Tourette's Disorder	_____
☐	Other (specify _____)	_____

Interviewer's Notes:

_____

_____

_____

_____

_____

_____

CHILD'S MEDICAL HISTORY

Place a check next to any illness or conditions that your child has. When you check an item, also note the approximate date for child's age at the time of the illness.

ILLNESS OR CONDITION	AGE OR DATES	ILLNESS OR CONDITION	AGE OR DATES
☐ AIDS or HIV positive	_____	☐ Head Injury	_____
☐ Allergies	_____	☐ Headaches	_____
☐ Anemia	_____	☐ Heart Disease or Problems	_____
☐ Aneurysm	_____	☐ Lead Poisoning	_____
☐ Anoxia	_____	☐ Hepatitis	_____
☐ Arteriovenuous Malformation	_____	☐ Herpes	_____
☐ Arthritis	_____	☐ High Blood Pressure	_____
☐ Asthma	_____	☐ Jaundice	_____
☐ Ataxia	_____	☐ Leukemia	_____
☐ Automobile Accident	_____	☐ Malnutrition	_____
☐ Back pains or problems	_____	☐ Meningitis	_____
☐ Bleeding problems	_____	☐ Muscular Disease	_____
☐ Blood Disorders	_____	☐ Pain problems	_____
☐ Bone or Joint disease	_____	☐ Paralysis	_____
☐ Broken Bones	_____	☐ Pituitary Disorder	_____
☐ Cancer	_____	☐ Pneumonia	_____
☐ Chorea	_____	☐ Poisoning	_____
☐ Coma	_____	☐ Poliomyelitis	_____
☐ Cystic Fibrosis	_____	☐ Rheumatic Fever	_____
☐ Dazed or Unconscious	_____	☐ Scarlet Fever	_____
☐ Dementia	_____	☐ Sensory Losses	_____
☐ Diabetes	_____	☐ Sexual Molestation	_____
☐ Dysarthria	_____	☐ Sexually Transmitted Disease	_____
☐ Dyspraxia (or Apraxia)	_____	☐ Speech and Language Problems	_____
☐ Ear Infections (PE tubes)	_____	☐ "Spells" (_____)	_____
☐ Other Ear problems	_____	☐ Stroke	_____
☐ Eczema or Hives	_____	☐ Suicide attempts or thoughts	_____
☐ Electric or Chemical Shock	_____	☐ Sunstroke or heat exhaustion	_____
☐ Encephalitis	_____	☐ Thyroid Disorder or Problem	_____
☐ Epilepsy, Seizures, Fits	_____	☐ Trauma	_____
☐ Fainting spells	_____	☐ Tumor	_____
☐ Fetal Alcohol Syndrome	_____	☐ Tuberculosis	_____
☐ Fever (if high or prolonged)	_____	☐ Visual Problems	_____
☐ Guillain-Barre Syndrome	_____	☐ Whooping Cough	_____

Indicate if the child has undergone any of these medical Tests (place check and give age):.

☐ Electroencephalogram (EEG)	_____	☐ Skull X-rays	_____
☐ CT Scan	_____	☐ MRI Scan	_____
☐ BEAM Study	_____	☐ Evoked Potentials	_____
☐ Ophthalmologic (Vision)	_____	☐ Audiological Evaluation	_____

OTHER MEDICAL PROBLEM(S):_____

Pediatrician's name and address: _____

History of prescribed medications other than for colds and minor infections, please list present medications first:

MEDICATION	AGE	REASON PRESCRIBED
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

DEVELOPMENTAL/SOCIAL HISTORY

PREGNANCY:

Was your child adopted? ☐ **Yes** ☐ **No** **Date of Adoption:** _____ **Child's age of adoption:** _____

Duration of pregnancy (weeks or months): _____

During the pregnancy, did the mother:

- ☐ suffer from illness or disease
- ☐ suffer from an accident
- ☐ undergo surgery
- ☐ take medication
- ☐ undergo X-ray studies
- ☐ smoke tobacco
- ☐ consume alcohol
- ☐ use drugs
- ☐ loss of consciousness in mother

Complications of pregnancy included:

- ☐ excessive vomiting
- ☐ excessive staining or blood loss
- ☐ threatened miscarriage
- ☐ infection
- ☐ toxemia
- ☐ diabetes
- ☐ high blood pressure
- ☐ poor nutrition
- ☐ amniocentesis

DELIVERY

Duration of Labor: ___ **hours** **Birth Weight:** ___**lbs.** ___**ozs.** **Length:** _____

Type of Labor: ☐ **Spontaneous** ☐ **Induced** **Forceps Used?** ☐**Yes** ☐**No** **Type of Delivery:** ☐**Normal** ☐**Breach** ☐**Caesarean**

Complications:

- ☐ none
- ☐ hemorrhage
- ☐ delay in breathing
- ☐ placental problems
- ☐ cord around neck
- ☐ other (specify _____)
- ☐ injury to infant

NEWBORN AND POST-DELIVERY PERIOD:

Total days baby was in hospital after delivery: ____ Was your baby in NICU? ☐ Yes ☐ No How Long? _____

Medications administered to baby: _____

Complications:

- ☐ none
- ☐ addiction
- ☐ anemia
- ☐ birth defects
- ☐ cyanosis (turned blue)
- ☐ jaundice (yellow skin)
- ☐ infection
- ☐ seizures
- ☐ trouble breathing
- ☐ vomiting
- ☐ intraventricular hemorrhage
- ☐ meconium staining or aspiration
- ☐ respirator and/or resuscitation required
- ☐ diarrhea

INFANCY – TODDLER PERIOD:

As a baby, the child was

- ☐ colic
- ☐ feeding problems
- ☐ sleeping problems
- ☐ frequent head banging
- ☐ excessive restlessness
- ☐ did not enjoy cuddling
- ☐ constantly into everything
- ☐ slow or unable to adapt to changes in routine
- ☐ excessively high ☐ or low ☐ activity level
- ☐ was not calmed by being held and/or stroked
- ☐ excessive number of accidents compared to other children
- ☐ withdrawal or other problems adjusting to new people and situations
- ☐ variable or irregular body functions (sleep, hunger, bowel movements, etc.

Were there any special problems in the growth and development of your during the first year? ☐ Yes ☐ No

If yes, then describe:

_____

_____

_____

DEVELOPMENTAL MILESTONES:

The following is a list of infant preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Walked alone	____	Stayed dry at night	____
Spoke first word	____	Fed self	____
Put several words together	____	Rode tricycle	____
		Became toilet-trained	____

Compared with other children, the child's early development was: ☐ Normal ☐ Delayed ☐ Advanced

EDUCATIONAL HISTORY:

Current School's Name: _____ **Current Grade:** _____

Teacher's Name: _____ **Grade(s) Repeated:** _____

Describe Academic and Any Other Classroom Problem:

_____
_____
_____
_____

Previous School Interventions:

_____
_____
_____
_____

Describe Recent School Performance (list report card grades):

_____

Describe Special Services Received: _____

Current Educational Problem Areas include:

☐ **reading**
☐ **arithmetic**
☐ **spelling**
☐ **suspension**
☐ **other subject(s)**
☐ **does not complete homework**
☐ **difficulty remembering**
☐ **has poor study skills**
☐ **excessive absences (reason: _____)**

☐ does not respect the rights of others
☐ fights with classmates
☐ detention
☐ disrupts classroom

☐ cheats
☐ frequently inattentive/distracted
☐ overactive
☐ writing and/or fidgety
☐ does not like school
☐ conflict(s) with teachers
☐ does not work well independently
☐ worries about school

When did your child's school problems first begin or first come to your attention?_____

HOME INFORMATION

Mother's name: _____ **Age:** ____ **Education:** _____

Occupation: _____ **Phone (home):**_____ **(work):** _____

Father's name: _____ **Age:** ____ **Education:** _____

Occupation: _____ **Phone (home):**_____ **(work):** _____

Stepmother's name: _____ **Age:** ____ **Education:** _____

Occupation: _____ **Phone (home):**_____ **(work):** _____

Stepfather's name: _____ **Age:** ____ **Education:** _____

Occupation: _____ **Phone (home):**_____ **(work):** _____

If parents are separated or divorced, how old was child when the separation occurred? _____

What are the current custody/visitation arrangements? _____

Does the other parent know about you seeking psychological services for your child? _____

If yes, have the consented to your child receiving such services? _____

List any other adults in the child's life with which he/she is close:

_____

List all people living in household:

NAME	RELATIONSHIP TO CHILD	AGE
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____

List any brothers or sisters (including stepfamily) who live outside the household:

NAME	RELATIONSHIP TO CHILD	AGE
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____

Other languages spoken in the home: _____

Describe any important information about home:

_____

_____

Please list rules of hour home or family: _____

What disciplinary techniques to do you use with your child?

_____

_____

Which disciplinary techniques are most effective in gaining your child's compliance? _____

_____

Is there anything else we should know about your child?

_____

_____

_____

_____

_____

_____

_____

_____

_____