

Experience the courage to heal and grow.

INTAKE INFORMATION-Child/Adolescent

Welcome to A Courageous Mind Counseling Please answer all information as completely as possible. If applicable, both mother and father should complete together. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your child's counselor will discuss your responses with you after he/she has reviewed the form.

Child's Name _____ Date of First Visit _____

Completed by _____ Relationship to Child _____

Date of Birth _____ Age _____ Sex: M F

Present Address _____

City _____ State _____ Zip _____

Employer _____

Home () _____ Cell () _____ Other () _____

May I leave a message on an answering machine? Yes No

Work () _____ May I contact you at work? Yes No

Best Time and Place to Call _____

Email address _____

May I send appointment reminders and receipts through email? Yes No

Child's Legal Guardian (Managing Conservator) _____

(If the child is not living with both natural parents, both adoptive parents, or only living parent, the clinic requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservators and signature page, before the child is seen).

Religious Preference _____

Parent/Guardian's Name _____

Biological or Adopted _____ If adopted, child's age at adoption _____

Child's Ethnic Background _____ Primary Language Spoken at Home _____

If child is not living with both natural parents:

Were parents married? _____ When? _____

Have parents divorced? _____ When? _____

Is either natural parent deceased? _____ When? _____

Other marriages? _____

Briefly explain any special living circumstances (foster-care, custody arrangements, visiting rights, etc.)

How long has the child resided at the present address? _____

Does the child share a bedroom with anyone? Y N If yes, with whom? _____

Education

Child's School _____ # Years attended _____ Grade _____

Teacher _____ School Counselor _____

Who referred you to this office? _____

Client Information

Has your child had any counseling or are they currently in any type of counseling? _____

Name, address and phone number of current therapist _____

How successful did you find previous counseling? _____

Is child currently seeing a psychiatrist? Y N

If yes, name, address, and phone # of psychiatrist _____

Is child taking any medication? Y N

If yes, what type of medication does the child take and what is the medication for?

Does it help? _____

When was child's last physical exam? _____ Given by whom? _____

What were the results? _____

Presenting Concerns

What is your main concern about your child?

How long has this concern existed? _____ In what setting does it occur? (circle all that apply)

Home School Church Sports Neighborhood Public place Other

Does this child have any academic concerns? Y N

If yes, please explain _____

Has he/she ever repeated a grade? _____ Which grade? _____

Has there been any abuse of the child? (please circle all that apply)

Physical Verbal Sexual Neglect

Please explain anything that was circled _____

Would this child say that he/she had many friends? Y N

Please explain _____

What are the typical difficulties this child has with brothers and/or sisters? _____

How does the child express anger? _____

Was there a time when the child seemed to be doing well in school and/or home? Y N

Describe _____

What does the child do well? _____

How will you know that things are changing as the process is ongoing? _____

What do you expect will be different when therapy is completed? _____

Developmental History

Pregnancy and Delivery:

Length of pregnancy: _____ weeks Birth weight: _____ lbs, _____ oz

Please describe any pregnancy complications: _____

Drug/Alcohol use during pregnancy? Y N

If yes, please explain: _____

Early Childhood: Check one in each column indicating when child showed development in each area.

Child Walked

__ less than 12 months

__ 12-24 months

__ 24-36 months

__ over 36 months

__ has never walked

Child Spoke Words

__ less than 12 months

__ 12-24 months

__ 24-36 months

- over 36 months
- has never spoken words

Spoke Sentences

- less than 12 months
- 12-24 months
- 24-36 months
- over 36 months
- has never spoken sentences

Child First Trained for Urination

- less than 12 months
- 12-24 months
- 24-36 months
- 3-5 years
- not yet trained

Child First Trained for Bowels

- less than 12 months
 - 12-24 months
 - 24-36 months
 - 3-5 years
 - not yet trained
- Since Initial Toilet Training
- Frequent wetting during day
 - Frequent wetting during night

Since Initial Toilet Training

- Frequent soiling during day
- Frequent soiling during night

Explain any of the above: _____

Puberty: Onset of puberty (breast development, menstruation, pubic hair, facial hair)

- under 10 years
- 10-12 years
- 12-14 years
- 14-16 years
- over 16 years
- no development

Illness and Diseases: Please check any illness or disease which child has had.

- asthma
- eczema
- diabetes
- cancer
- measles
- mumps
- chicken pox
- diphtheria
- scarlet fever
- polio

- cerebral palsy
- lead poisoning
- encephalitis
- tuberculosis
- heart disease
- influenza
- migraine headaches
- undescended testicles
- high blood pressure
- low blood pressure
- sinusitis
- appendicitis
- heart surgery
- tonsillectomy
- convulsions
- brain injury
- fainting
- dizziness
- meningitis
- broken bone
- others (write in)

Hospitalizations: Please list any hospitalizations, age and length of stay.

Conditions for which hospitalized	Age	Length of Stay
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Social & Behavioral: Please check the items the child has difficulty with.

<input type="checkbox"/> auditory	<input type="checkbox"/> focus on objects; not people	<input type="checkbox"/> physical aggression
<input type="checkbox"/> bed wetting	<input type="checkbox"/> forgets	<input type="checkbox"/> rocking body
<input type="checkbox"/> blanking out	<input type="checkbox"/> giving up	<input type="checkbox"/> shyness
<input type="checkbox"/> breath holding	<input type="checkbox"/> habits	<input type="checkbox"/> sibling conflict
<input type="checkbox"/> can't fall asleep	<input type="checkbox"/> head banging	<input type="checkbox"/> sleep walking
<input type="checkbox"/> clumsiness	<input type="checkbox"/> hyperactivity	<input type="checkbox"/> social isolation
<input type="checkbox"/> constipation	<input type="checkbox"/> impulsivity	<input type="checkbox"/> slowness to learn
<input type="checkbox"/> coordination	<input type="checkbox"/> interrupted sleep	<input type="checkbox"/> soiling
<input type="checkbox"/> dangerous behavior	<input type="checkbox"/> mannerisms	<input type="checkbox"/> speech
<input type="checkbox"/> daredevil behavior	<input type="checkbox"/> nail biting	<input type="checkbox"/> stubbornness, rigidity

<input type="checkbox"/> diarrhea	<input type="checkbox"/> night terrors	<input type="checkbox"/> tantrums
<input type="checkbox"/> early waking	<input type="checkbox"/> nightmares	<input type="checkbox"/> thumb sucking
<input type="checkbox"/> eating	<input type="checkbox"/> verbal aggression	<input type="checkbox"/> fears
<input type="checkbox"/> vision	<input type="checkbox"/> other language	<input type="checkbox"/> other (describe)

Family History

Check all of the following family concerns that apply currently or in the last 6 months__ Marital difficulties

- Aging grandparents
- Alcoholism
- Serious illness of child
- Serious illness of relative
- Older sibling leaving home
- Recent death in family
- Recent death of friend
- Drug addiction in family
- Financial problems
- Birth of a sibling
- Step parent in the home
- Move to a new home
- Traumatic experience
- Move to a new school
- Other (specify) _____

Has there been anyone in either parent’s family who has been treated for mental illness? Y N

If yes, please explain: _____

Has anyone in either parent’s family been prescribed medication for depression, bipolar disorder, or anxiety? Y N

If yes, please explain: _____

Has anyone in either parent’s family been treated for alcoholism and drugs? Y N

If yes, please explain: _____

Describe briefly any special interest, hobbies, and recreational activities in which family members partake:

Child: _____

Mother: _____

Father: _____

Brothers/Sisters:

Please list all those living in child’s home:

Name	Relationship	Date of Birth	Employer/School

Please list all other persons closely involved with child but not living in home:

Name	Relationship	Date of Birth	Employer/School

Describe an important family value _____

How would you describe the child as a person? _____

Name of adult completing this form: _____

Relationship to child: _____

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____

Therapist Signature _____ Date: _____

* Developed by the Community Counseling Play Therapy Center, MidAmerica Nazarene University.
 Adapted by Jessica Almond, PLPC.