Office Use Only

Client # _____

Ins. Dx: _____

Need Monthly Statement?
□ Yes □ No
EAP □ Yes □ No
□ Individual □ Family

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CHILD /ADOLESCENT CLIENT INTAKE FORM

Today's Date: _____

GENERAL INFORMATION – *Please print*

Client Name: Last _____ First: _____ MI: _____

Mailing Address: _____ City: _____ State: _____

Zip: _____

Client's DOB: _____/_____/_____ Age: ____ □ Male □Female □Other _____

SSN: _____-_____-_____

School Attending: _____ Grade: _____

Racial/ethnic identity: □ American Indian/Alaska Native □ Asian/Asian Indian □Black /African American

□Hispanic/Latino □ Middle Eastern □ Pacific Islander /Native Hawaiian □ White

Responsible Party

Client Name: Last _____ First: _____ MI: _____

Mailing Address: _____ City:_____ State: _____

Zip: _____ Email: _____

DOB: _____(if applicable as payee)

Home Phone _____ Can a message be left at this number □ Yes □No

Cell Phone _____ Can a message be left at this number □ Yes □No

Emergency Contact: _____ Phone#:_____ Relationship: _____

Referred by: _____ May we thank the person? □ Yes □No

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INSURANCE INFORMATION *(if applicable)*

Policyholder's Name: _____ Policy Holder's Date of Birth: _____
Policyholder's Employer: _____
Street Address: _____ City: _____ State: _____
Zip _____

Primary Insurance Carrier: _____ (Behavioral Health) Phone #:_____
City: _____ State: _____ Zip: _____
Member #_____ Group #_____
Issue Date _____

Secondary Insurance Carrier: _____ (Behavioral Health) Phone #:_____
City: _____ State: _____ Zip: _____
Member #_____ Group #_____
Issue Date _____

FAMILY INFORMATION

Parents' Marital Status: □ Single □ Engaged □ Married/Partnered □ Separated □ Divorced □ Widowed

Mother's Name: _____ DOB: ___/___/___ Age: ____

	Preferred	Leave msg?	
Home Phone _____	□	□	Email Address: _____
Work Phone _____	□	□	
Cell Phone _____	□	□	Employer: _____

Father's Name: _____ DOB: ___/___/___ Age:_____

	Preferred	Leave msg?	
Home Phone _____	□	□	Email Address: _____
Work Phone _____	□	□	
Cell Phone _____	□	□	Employer: _____

Others living in child's home:

Name	**Relationship to Child**	**DOB**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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_____ _____ _____
_____ _____ _____
_____ _____ _____

Legal Custodian (if applicable): _____

COUNSELING CONCERNS

Why are you seeking help for your child now?

_____
_____
_____
_____

What would you like to see happen as a result of counseling or psychotherapy?

_____
_____
_____
_____

Has your child ever wished to be dead or wished he/she could go to sleep and not wake up?_____

_____
_____
_____

Has your child had any thoughts of killing himself/herself?

_____
_____
_____

For the child/adolescent: Have you ever done anything, started anything, or prepared to do anything to end your life? If yes, how long ago did you do any of these things?

_____
_____
_____
_____

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DEVELOPMENTAL HISTORY

Are you aware of any complications with the client's pregnancy and birth? If yes, please describe

_____
_____
_____

When did client achieve the following developmental milestones?

Milestone	Age
Sitting up	_____
Turning over	_____
Talking	_____
Crawling	_____
Walking	_____
Potty trained	_____

MEDICAL & PSYCHIATRIC HISTORY

Physician's Name: _____ Physician's Phone: _____
Date of last physical: _____

List physical illnesses or symptoms □ Check if none

_____
_____
_____
_____

Has the client ever been hospitalized overnight for medical reasons? If yes, please list

_____
_____
_____

Current Medication	Dosage	Frequency	Prescribing MD
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychiatrist's Name: _____ Psychiatrist's Phone: _____

Has your child ever had counseling or psychotherapy in the past? ___ Yes ___ No
If yes, when? _____ With whom? _____
_____

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_____

Has your child ever been hospitalized for mental health reasons before? ___ Yes ___ No
If yes, when? _____ With whom? _____

Has your child been seen by this office in the past? ___ Yes ___ No
If yes, when? _____ With whom? _____

Have you or any other family member received help for drug or alcohol dependency? □Yes □ No
If yes, when? _____ Where? _____

Check which of the following your child uses, and note the amount and frequency of each:
□ Caffeine: _____ □ Tobacco:_____
□Coffee □Sodas □Other Drinks □ Pills

□ Alcohol:_____ □ Marijuana: _____
□ Cocaine, Crack: _____ □ LSD: _____
□ Inhalants: _____ □ Other: _____

Have you ever been concerned about your child's use of drugs/alcohol? □ Yes □No

Has your child been concerned or felt guilty about his/her use of drugs/alcohol? □ Yes □No

Has anyone ever expressed concern about your child's use of drugs/alcohol? □ Yes □No
If yes, who? _____

Are drugs used in the home? □ Yes □No
If so, what and by whom? _____

Is alcohol used in the home? □ Yes □No
If so, what and by whom? _____

Does anyone in the home smoke? □ Yes □No
If so, who does and how much? _____

SCHOOL HISTORY

Schools Attended

Kindergarten _____ Seventh Grade _____
First Grade _____ Eighth Grade _____
Second Grade _____ Ninth Grade _____
Third Grade _____ Tenth Grade _____

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Fourth Grade _____ Eleventh Grade _____
Fifth Grade _____ Twelfth Grade _____
Sixth Grade _____ Other _____

Has the client ever received special education services? If yes, Please explain:
_____
_____
_____
Describe the client's grades throughout his/her school career:
_____
_____
_____
Describe the client's conduct throughout his/her school career:
_____
_____
_____
Describe the client's school attendance:
_____
_____
_____
Has the client ever been suspended or expelled? If yes, please explain
_____
_____
_____

Interests and Accomplishments

What are your child's main hobbies and interests? _____
_____
_____

What are your child's areas of greatest accomplishment? _____
_____

What does your child enjoy doing most? _____
_____

What does your child dislike doing most? _____

What do you like about your child? _____

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_____

How much time does your child spend:

Doing homework? _____
Playing video games? _____
Exercising? _____
Sleeping? _____

Watching TV? _____
On the computer? _____
Socializing with friends? _____
Texting/Talking on the phone _____

Checklist of Concerns for Children & Adolescents

__ Careless
__ Poor sustained attention
__ Doesn't listen
__ Poor follow-through
__ Poor organization
__ Loses things
__ Easily distracted
__ Forgetful in daily activities
__ Poor decision-making
__Frequent trouble at school

__ Fidgets
__ Out-of-seat
__ Runs about
__ Problems being quiet
__ Talks excessively
__ Calls out
__ Doesn't wait turn
__ Interrupts
__Negative peer group

__ Loses temper
__ Argumentative with adults
__ Angry or resentful
__ Refuses to comply
__ Deliberately annoys
__ Projects blame
__ Easily annoyed
__ Spiteful or vindictive
__ Low self-esteem

__ Bullies
__ Destroys Property
__ Physical fights
__ Cruel to animals/people
__ Uses a weapon
__ Steals
__ Truant from school
__ Sets fires
__Poor peer relationships

I give permission to Anissa Howard Counseling & Psychotherapy Services, LLC to treat the minor I am bringing for counseling.

_____ _____ _____
Signature of parent/guardian *Date* *Printed name of parent/guardian*

Would you like to join our email list for upcoming workshops and groups? □Yes □No
If so, please provide your email address if different from responsible party/parents' email :
_____

(We respect your email privacy. You will not receive unsolicited marketing. We will not share, transfer, sell or rent your information.)

(The information requested in this form will be kept confidential.)