Child and Adolescent Intake Form

Date: _____

Identifying Data

Name: _____ Birthdate: _____ Age: _____

Name of person completing form: _____ Relationship to client: _____

Emergency Contact and phone: _____

Father's Name: _____ Age: ___ Occupation: _____ Education level: _____

Mother's Name: _____ Age: ___ Occupation: _____ Education level: _____

Adolescent resides with: _____ If Divorced, custody arrangement: _____

Step Parent(s) Name(s):_____

Reason for visit:_____

Referred by (if applicable): _____

Family and social history

Names of siblings:	**Age:**	**Gender:**	**Grade:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is the adolescent or their sibling(s) adopted? _____

Household members:

_____

Dates of marriages, separations, divorces (if applicable):

_____

Involvement in social services, child protection or court system?

_____

Physical, sexual or emotional abuse known: _____

Religious/spiritual practices/affiliations: _____

Relationships with peers (check all that apply) ___ Leader ___ Makes friends easily ___ Follower

___Has difficulty making friends ___Has Long-time Friends ___Well liked by peers ___Shares Easily

___ Loner ___Bullied ___Bullies others ___Recent Changes in Friends ___ Shy with peers

Other concerns about peer relationships: _____

Describe any concerns with adult relationships: _____

School and work History

Current School: _____ Grade: _____ GPA _____ Recent changes in grades ___ yes ___ no

Previous schools: _____

Concerns with school: _____

List school activities (clubs, sports, job) outside of school and number of hours the activities take per week:

_____

Health Information

List problems in the pregnancy, labor or birth of the client: _____

Concerns or delays in their development ___Speech and Language ___Hearing ___Vision ___Intelligence/learning

___ Bladder/Bowel Control ___Emotional/Maturity Level ___Social Skills ___Eating Habits ___Fine/Gross Motor /Skills

Primary Care Clinic Location/ Physician Name: _____

Date of Last Medical Exam: _____ Current Physical Condition: ___poor ____ Fair ____Good ____Excellent

Current Medical Conditions: _____

List hospitalizations/surgeries/conditions: _____

Current Medications: _____

For those 12 years and older

Have you ever tried alcohol or illicit drugs? □No □Yes

Have you used more than one chemical at the same time in order to get high? □ No □Yes

Do you avoid family activities so you can use? □ No □Yes

Do you have a group of friends who use? □ No □Yes

Do you use to improve your emotions such as when you feel sad or depressed? □ No □Yes

List the substances you have tried or used in the past or are currently using: _____

Please check all symptoms that have occurred over the past month:

□ Depressed mood	**□ Excitability/Excessive energy**	**□ Tenseness**
□ Thoughts to harm self	**□ Feeling overwhelmed**	**□ Mood swings**
□ Hopelessness	**□ Problems concentrating/focusing**	**□ Destroying property**
□ Irritability	**□ Regressive behaviors**	**□ Nightmares**
□ Low motivation/less interest in things	**□ Ruminating thoughts**	**□ Disregard for others**
□ Isolative/withdrawn from others	**□ Rapid speech**	**□ Impulsivity**
□ More tired than usual	**□ Hearing voices**	**□ Thoughts to harm others**
□ Avoidance of people or tasks	**□ Panicky feeling**	**□ Self Injury**

Other concerns: _____