Child/Adolescent Intake Form – **PLEASE PRINT CLEARLY**

Child’s Full Name: Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Date of Birth:

Address (Street, City, Zip):

Gender: MALE FEMALE

Parent/Guardian Phone: Can we leave a private message at this number? Y / N

Emergency Contact Phone / Relationship to Child:

**Insurance and Billing Information (private pay clients - skip this section)**

**Please PRINT CLEARLY and complete ALL the information below if you are using your insurance. Failure to do so may result in the claim being returned; the parent/guardian will be responsible for the full therapist fee for claims denied due to incorrect or incomplete information on this form.**

Insurance Carrier/Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copay Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Individual/Family Deductible Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number (for billing purposes only): \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Policy holder’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s relationship to policy holder (circle one): SELF SPOUSE CHILD OTHER

Policy holder’s full date of birth if different from client: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Policy holder’s full address if different from client (street, city, state, zip):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s name of employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s gender: MALE FEMALE

Policy holder’s Phone if different from client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral Assets:

What does your child do that you like? What does he /she do that other people like?

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Excesses:

What does your child currently do too often, too much, or at the wrong times that causes negative consequences for him/her? Please list all the behaviors you can think of.

Others Concerns:

Do you have any other concerns about your child or your family that you have not mentioned above.

Treatment Goals:

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Family History:

Biological parents and/or guardian information:

Mother Name: Father Name:

Phone: Phone:

Email: Email:

Who has legal guardianship of your child? Guardian (if not parents) Name:

 Phone/Email:

Who does your child currently live with?

Names Ages Relationship to child Grade/Job

1.

2.

3.

4.

5.

Who are your child's significant others NOT living with your child (friends, relatives, etc)?

Names Ages Relationship to child

1.

2.

3.

Please describe any past counseling or diagnoses that either your child or any family member has had (include up to 2 generations).

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol?

If yes, Please describe:

Education History:

What school does your child attend?

Address:

Phone: Teachers Name:

Current Grade:

What does your child's teacher say about him/her?

Other schools attended (including Pre-school)

Has your child ever repeated a grade? If so which one(s)?

Has your child ever received special education services?

Has your child experienced any of the following problems at School? (circle all that apply)

\* fighting \* lack of friends \* drug/alcohol \* detention

\* suspension \* learning disabilities \* poor attendance \* poor grades

\* gang influence \* incomplete homework \* behavior problems

Medical History:

What is the name of your child's medical doctor?

Address: Phone:

Date of your child's last medical examination:

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, Please describe them:

Has your child experienced any of the following medical problems? (circle all that apply)

\* A serious accident \* Hospitalization \* Surgery \* Asthma

\* A head injury \* High fever \* Convulsions/seizures \* Eye/ear problems

\* Meningitis \* Hearing problems \* Allergies

\* Loss of consciousness \* Other (describe):

For any of the above medical problems that are circled, please give additional information below:

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal)? If so please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?

If yes to either question please describe the situation (use back if necessary):

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker, loss of extended family member or a beloved pet, moving, deployments, etc.)?

If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family (use another page if necessary)?