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CHILD & ADOLESCENT INTAKE & PERSONAL HISTORY FORM

Name: _____ Social Security #:_____

Gender: ___ F ___ M Date of birth: _____ Age: _____
Form completed by (if someone other than client): _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (home): _____ (cell): _____
Person Responsible for Payment _____ Soc. Sec #_____
Relationship _____
Signature of Person Responsible for Payment **X**_____ Date: _____
Must be signed for services to begin

Pharmacy Information
Name: _____ Address: _____ Phone: _____

Emergency Information *In case of emergency, contact:*
Name: _____ Relationship: _____ Phone: _____

Referral Source
How did you hear about our office (or from whom)? _____
_____

Primary reason(s) for seeking services: (*please describe*)
_____
_____

Current issues: *(when started? How problems affect functioning? What makes it better? worse?)*
_____
_____
_____
_____

Prior Psychiatric Treatment History:
Prior Counseling *(if yes, give name, dates and reason for treatment)*: _____
_____
Prior Hospitalizations *(if yes, give name, dates and reason for treatment)*:_____
_____
Prior Medication Trials *(if yes, give name, dates and +/- effects if any)*: _____
_____
_____
Has the child/adolescent experienced death? (friends, family, pets, other) ___ Yes ___ No
At what age? _____ If Yes, describe reaction: _____
_____

Have there been any other significant changes or events in your child's life? (Family, moving, fire, etc.)
__ Yes ___ No If Yes, describe: _____

_____

Medical/Physical Health:
List any health concerns *(current and past*): _____

_____

Pediatrician/Primary Care Physician (name, address & phone #): _____

_____

List any prior surgeries: _____

_____

***ALLERGIES** to medications?: *(if yes, describe reaction)*_____

Current prescribed medications	Dose	Dates	Purpose	Side effects

Family History:

Child's Mother

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT
Where employed: _____ Work phone: _____
Mother's education: _____
Is the child currently living with mother? ___ Yes ___ No
__ Natural parent ___ Step-parent ___Adoptive parent __Foster home ___ Other (specify): _____
Is there anything notable, unusual or stressful about the child's relationship with the mother?
__ Yes ___ No If Yes, please explain: _____

_____

How is the child disciplined by the mother? _____
For what reasons is the child disciplined by the mother? _____

Child's Father

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT
Where employed: _____ Work phone: _____
Father's education: _____
Is the child currently living with father? __ Yes ___ No
__ Natural parent ___ Step-parent ___Adoptive parent __Foster home ___ Other (specify): _____
Is there anything notable, unusual or stressful about the child's relationship with the father?
__ Yes ___ No If Yes, please explain: _____

_____

How is the child disciplined by the father? _____
For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household *(give name & age and describe relationship)*

_____

_____

_____

_____

_____

Family Health History

Please list any diseases/ genetic illnesses occurring among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents), *(please esp. include any psychiatric illness occurring in family, i.e. depression, manic-depression, drug/alcohol dependence, ADHD, learning disability, etc)*

_____

_____

_____

Childhood/Adolescent Developmental History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? ___ Yes ____ No

If Yes, describe: _____

Was the pregnancy with child planned? __ Yes ____ No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number ____ of __ total children.

While pregnant did the mother smoke cigarettes? __Yes __ No, If Yes, what amount: _____

Did the mother use drugs or alcohol? ____ Yes ____ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication, trauma) ____ Yes ___ No

If Yes, describe: _____

Length of labor: _____ Induced: ____ Yes ____ No Caesarean? ____ Yes ____ No

Baby's birth weight: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____
Spoke words: _____ Rode two-wheeled bike: _____
Spoke sentences: _____ Toilet trained: _____
Weaned: _____ Dry during day: _____
Fed self: _____ Dry during night: _____

Age for following developments (fill in where applicable)
Began puberty: _____ Menstruation: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

_____

_____

Education

Current school: _____ School phone number: _____

Type of school: ____ Public ____ Private ___ Home schooled ____ Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? ____ Yes ___ No If Yes, describe: _____

In gifted program? ___ Yes ____ No If Yes, describe: _____

Has child ever been held back in school? ____ Yes ____ No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? __ Yes ____ No

If Yes, describe: _____

Has the child been tested psychologically? ____ Yes ____ No

If Yes, describe: _____

Child's Approach to School Work:

___ Organized ____ Industrious ____ Responsible ____ Interested
___ Self-directed ____ No initiative ____ Refuses ____ Does only what is expected
___ Sloppy ____ Disorganized ____ Cooperative ____ Doesn't complete assignments
___ Other (describe): _____

Child's Peer Relationships:

___ Spontaneous ____ Follower ____ Leader ____ Difficulty making friends
___ Makes friends easily ____ Long-time friends ____ Shares easily
___ Other (describe): _____

Chemical Use History

Do you suspect or does your child use or have a problem with alcohol or drugs? ____ Yes __ No
If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

What are your goals for the child's therapy? _____

_____

_____

_____