CHILD / ADOLESCENT
INTAKE ASSESSMENT Date_________________________

Child's name____________________________________ M F
Address____ DOB________________________
City________________________ State___________ Zip Code__________ Phone# _______________________
Parent(s)/Guardian(s)____
Email Address ______________________________________Alternate Phone #__________________________
Emergency contact__________________________ Relationship_______________ Phone_________________
Who lives in the home at the current time? (Name, age, relationship) ____________________________
____
____
____
Reason for seeking counseling: ____
____
____
____

Has the child had previous counseling: _____ Yes ______ No _____ Only as part of family

Where ____ When____________________________________
Was it helpful? ____
____
____

Has the child had previous substance abuse treatment? ____ Yes ____No _____Only as part of family

Where ____ When__________________________________
Was it helpful? ____
____
____

EDUCATIONAL HISTORY

School____ Grade________ Teacher______________________

School Counselor / Social Worker____
Has the child ever been diagnosed? _____ Learning Disability _____ ADHD _____ Sensory Integrative
______Autism _____ Oppositional Debiant _____ Emotionally Impaired
_____ Pervasive Development Dis. ______ Physical Impairment
Describe the child's academic performance____
____
Does the child struggle with distractibility? ____ Yes _____ No ______ School thinks so, I'm not sure
_______ Sometimes

Has the child struggled with any of the following? _____ Truancy ____ Suspension ____Fighting

____ Vandalism ____Expulsion _____Debiance ____School refusal ____Threatening behaviors
____ Weapons ____ Separated from parent

What does the child do well at school? ____

Has the child ever been held back? ____ No ____ Yes, when? ________________________________

LEGAL SYSTEM INVOLVEMENT

Has the child been involved with the legal system? ____ Yes, in the past ____ Currently ____ No

If so, please explain ____
____

Is the child on probation? _____ No _____ Yes, probation ofbicer ______________________________

FAMILY HISTORY

Does anyone in the extended family unit have a history of alcoholism? ___ No ____ Yes, please

explain ____
____

Drug abuse? ____No ____Yes, please explain____
Depression? ____No ____ Yes, please explain____
Anxiety? ____ No ____Yes, please explain ____
Mental Illness? ____No ____Yes, please explain____
Has the child ever been abused? ____No ____Yes, ____Physical ____Emotional ____Sexual
____ Spiritual ____ Verbal
Explain ____

HEALTH HISTORY

Where was the child born? _______________________________ Adopted? ____ No ____Yes, at age_______

Explain any complications the mother had during pregnancy or labor _________________________
____

Child's physician / pediatrician ____
Is the child being treated for a medical condition? ____
____
____

Please list hospitalizations ____
____

Please list current medications ____

____
____
____
Please list current allergies ____
____
Has the child ever had a seizure? _____ No _____Yes, specify ________________________
Has the child ever had a head injury? _____ No _____Yes, specify _____________________
Does the child complain of frequent headaches? _____ No _____Yes, specify ______________
Does the child complain of dizziness? _____No _____Yes, specify _____________________
Does the child have current difbiculties with wetting/soiling? _____No _____Yes, specify ________
____
Does the child have adequate personal hygiene habits? _____ No _____Yes

At what age did the child walk _____________ Talk ___________ Complete toilet training _________

Eating habits? ____ No change ____ Not eating ____ Over-eating ____ Signibicant Weight Change _____ lbs.
_____ Selective Eating Habits _________________________ _____ Other ___________
Sleeping Habits? _____No Change _____ Trouble Getting to Sleep _____ Trouble Staying Asleep
_____ Early Waking _____ Sleepwalking _____ Nightmares/terrors _____ Other __________

HARMFUL BEHAVIORS

Are you concerned about suicidal statements or gestures with the child? _____ No _____ Yes, explain

____
Prior attempt? Explain ____

Are you concerned about the child seriously injuring others? ____ No _____Yes, explain _________

____
Prior attempt? Explain ____

Others risk/safety factors____

____

PERSONALITY

Does the child form friendships easily? _____Yes _____ No _____ Only in small crowds

Does the child struggle with any of the following? _____ "Late Bloomer" _____ Bullying _____ Easy Target _____ Extremely Shy _____ Needs Social Reassurance _____ Other _____________
Who is the child's best friend at the current time? ____________________________
What does the child do well socially? ______________________________________
____
____
What are some of the child's favorite activities / toys? ___________________________

____
____
____
Is the child part of any groups/organizations ____No _____Yes
If yes, what? ____
Cultural Heritage ____

SPIRITUALITY

Is your family afbiliated with a church? _____ No _____Yes, where? ___________________________________

Who is the minister/reverend? ____
How often do you attend? ____ Regularly _____ Sporadically _____ Holidays _____ Never
Is the child involved in a church youth group? _____ No _____ Yes _____ Sometimes

PREPARATION FOR COUNSELING

Have you spoken with the child about why he / she is coming to counseling? ____ No _____ Yes

What is the last major change in the child's life? ____
____
Has the child ever experienced a traumatic event? _____ No _____ Yes, explain ________________________
____

Is there anything else that the therapist should know about the child? ______________________________

____
____
____
Is there anyone else who should be invited into the counseling process with the child? _____ No
_____ Yes, whom? ____
Comments ____
____
____

TREATMENT PLANNING

What would you like to see occur from counseling services for the child? ___________________________

____
____
____
How frequently would you like the child's counseling sessions to be scheduled?
____ as needed ____ 1x/month _____ 2x/month _____ 3x/month _____ 4x/month _____ don't know yet

Is everyone in the child's family aware of the concerns? _____ Yes _____ No

Is everyone in the family willing to participate in counseling? _____ Yes _____ No ______ Don't know

Is there anything else the child's counselor should know? ____

____
____
____
____
____

Therapist Review: Date:

____