CLIENT INFORMATION Date ______________

Intake Information for Child/Youth

Name ____DOB___________________________

Address ___________________________________Apt. ________ Home Phone _______________

City ______________________________State _____ Zip ________ Work Phone _______________

Employer/School ____________________________Occupation/Studying _____________________

Emergency contact information____

____

Legal Guardian/Parent Information

Name ____DOB___________________________

Address ___________________________________Apt. ________ Home Phone _______________

City ______________________________State _____ Zip ________ Work Phone _______________

Employer/School ____________________________Occupation/Studying _____________________

Cell Phone _______________ Email ____

Additional Legal Guardian/Parent Information

Name ____DOB___________________________

Address ___________________________________Apt. ________ Home Phone _______________

City ______________________________State _____ Zip ________ Work Phone _______________

Employer/School ____________________________Occupation/Studying _____________________

Cell Phone _______________ Email ____

Referral Information

How did you hear about my services? Please mark the option that applies:

___ Internet
___ Referral from a friend or family member
___ School staff
___ Another mental health professional
___ Other, please specify:
____

Family Information

With whom does the child/youth currently live?

____

	First Name	How frequently does the child/youth see this person?	How does the child/youth get along with this person? Please use a 1 to 5 scale with 1 indicating a highly problematic relationship.
Parent/Guardian			
Parent/Guardian			
Step-Parents			
Grandparents			
Uncles/Aunts			
Brothers			
Sisters			

Is there a family history of:

Depression Suicide Attempts Anxiety Eating Disorders Mental Illness

Violence Sexual Abuse Emotional Abuse Alcoholism/Drug Addiction

Chronic Illness Other, please specify ____

Please explain any chronic illness

____

____

Social/Academic Information

Child/Youth's Grade in School _____ Identified needs? 504 Plan ___ ILP ___ IEP ___ ALP-GT ___

Brief description: ____

____

Does the child/youth like school? Yes ___ No ___

Specific concerns or problems at school not already described? ______________________

____

Describe strengths of the child/youth: ____

____

Describe challenges of the child/youth: ____

____

Child/Youth Interests:

School ____

____

Community ____

____

Music/Art ____

____

Sports ____

____

Please list the first names of the child's/youth's significant friends and indicate how long those friendships have been in place.

First Name	How Long	How often does the child/youth see this friend?

Tell a little about these friends. Does the child/youth feel close to them? Is the child/youth happy with the friendships as they are now? Would he/she like something to change to make them better?

____

____

____

Spiritual Resources

How significant a role does spirituality play in the child/youth's life?

None _____ Somewhat important _____ Significant _____ Very Significant _____

Religious Orientation or Spiritual Practice ____

____

Child/Youth Medical History

Primary Physician ______________________________________ Phone ___________________

Date of Last Exam _________________________

Major or Chronic Illnesses/Injuries

____

____

Operations

____

Current Medications	Dosage	Frequency	Effectiveness	Prescribing Physician

Have there been recent changes in any of the following areas?

Sleep Behaviors Amount of Exercise Eating/Appetite Weight

Please describe the change:

____

Substance Use - Youth

Tobacco

Does the youth smoke? Yes ___ No ___

Has the youth smoked in the past? Yes ___ No ___

If yes, how many cigarettes per day? ____ Began at what age? ____

If youth no longer smokes, when did he/she quit? ____________________

Alcohol

Does the youth consume alcohol? Yes ___ No ___

If so, how much?

Less than 1x/month ___ 1-3x/month ___ 1x/week ___ Several x's/week ___ Every day ___

Drugs

Does the youth use any street drugs or misuse prescription drugs? Yes ___ No ___ If yes, list:

Name of Drug	Frequency of Use

Counseling/Psychotherapy Information

Please describe the main concerns that prompted your family to seek counseling/psychotherapy?

____

____

How have these concerns evolved or changed over time?

____

____

____

Please indicate what major stressors the child/youth has had in the last 12 months.

Serious Illness or Injury ___ Death of a Close Friend or Family Member ___ Major Illness in Family ___

Gain of New Family Member ___ School Change ___ Divorce/Separation ___ Job Change ___

Other ____

What would you like to be different in your family or with the child/youth when therapy ends?

____

____

Has the child/youth ever received psychological or psychiatric counseling before? Yes ___ No ___
If so, please describe when, from whom, the purpose and results:

____

____

Has the child/youth ever been prescribed medicine for psychiatric or emotional problems? Yes __ No __
If so, please describe when, the prescribing clinician, what medication, for what, and the results:

____

____

Has the child/youth ever been hospitalized for a psychiatric or emotional health reason? Yes ___ No ___
If so, please describe when, where, for what reason, and the results:

____

____

Has the child/youth ever been in a drug or alcohol rehab program? Yes ___ No ___
If yes, how many times? ___ When? _________________ Inpatient ___ Outpatient ___ How long? ___

Outcome? ____

____

Please indicate if the child/youth has experienced any current or past issues in the following areas:

Physical, Sexual or Emotional Abuse ____

Harming Self ____

Violent Behaviors ____

Mental Illness of Family Member ____

Legal Problems ____

Is there anything else you think I should know about before I begin working with the child/youth?

____

____

Thank you for your time in filling out this information.

I look forward to working with you.