Child & Teen Intake Form

Please complete all sections, print, and bring it with you to your first appointment.

1 | CLIENT INFORMATION

Date of First Appointment
MM / DD / YYYY

Child's First Name

Child's Last Name

Date of Birth
MM / DD / YYYY

Age

Sex
Male Female Prefer not to disclose

Eye Color

Ethnicity

Height

Weight

Street Address

City

State

Zip Code

County

Who has physical custody of the child?

Who is Legal Guardian?
Parent Other (specify below)

If Other, please specify

2 | PRIMARY PARENT/GUARDIAN CONTACT INFORMATION

Home Phone Number

Mobile Phone Number

Email Address

Neighborhood Environment (select all that apply)

- ☐ Rural
- ☐ Suburban
- ☐ City
- ☐ Safe
- ☐ Unsafe (crime, busy roads, etc.)

Insurance

Primary Insurance (Company Name)

Member ID

Group Number

Card Holder Name

Card Holder Date of Birth (if other than child)

MM / DD / YYYY

Secondary Insurance or Medicaid — 10 Digit Number

3 | FAMILY INFORMATION

Mother / Guardian

Mother's First Name

Mother's Last Name

Age

Specify Relationship to Child

- ○ Biological
- ○ Adoptive
- ○ Foster
- ○ Legal Guardian
- ○ Other

Place of Residence (if different from child)

Marital Status

- ○ Married
- ○ Divorced
- ○ Separated
- ○ Single
- ○ Never Married
- ○ Re-Married

Stepparent Name (if applicable)

Father / Guardian

Father's First Name

Father's Last Name

Age

Specify Relationship to Child

- Biological
- Adoptive
- Foster
- Legal Guardian
- Other

If Other, please specify

Place of Residence (if different from child)

Marital Status

- Married
- Divorced
- Separated
- Single
- Never Married
- Re-Married

Stepparent Name (if applicable)

Household

Please list all those who live in the home with the child (name, age, relationship, special needs):

Household Members

Any siblings living outside of the home and their age:

Siblings Outside the Home

Mother/Guardian Occupation

Father/Guardian Occupation

Family's Religious Affiliation (optional)

School Information

School Name

School District

Grade

Does the child receive Special Education services? Yes No

If yes, choose the type

Learning Support Autism Emotional Support Other

If Other, please specify

4 | CHILD HEALTH & MEDICATION HISTORY

Any previous mental health diagnoses? Yes No

If yes, please specify (include all that apply)

History of child being psychiatrically hospitalized? Yes No

If yes, please specify

Current Medications

List up to five current medications.

Name	Dose

Past Medications

List up to five past medications.

Name	Dose	Reason Discontinued

Who prescribes/prescribed the medication?

Pediatrician Name

Practice Name

Pediatrician/Practice Phone Number

Month/Year of Last Visit

5 | REVIEW OF SYSTEMS: PARENT CHECKLIST

Please check all that apply in each system.

General System

- ☐ Recent weight changes
- ☐ Unusually high energy
- ☐ Prolonged high fever
- ☐ Visual deficits
- ☐ Hearing deficits
- ☐ None of the above
- ☐ Notable fatigue or low energy
- ☐ Frequent illnesses or fevers
- ☐ Serious medical conditions
- ☐ Corrective lenses
- ☐ Hearing aides

Sleep System

- ☐ Difficulty falling asleep
- ☐ Restless or poor-quality sleep
- ☐ Snoring, or pauses in breathing
- ☐ Difficulty staying asleep
- ☐ Nightmares
- ☐ None of the above

Neurological System

- [ ] Headaches or migraines
- [ ] Loss of consciousness
- [ ] Tics or tremors
- [ ] Problems with balance or coordination
- [ ] History of head injury or concussion
- [ ] Seizures or staring spells
- [ ] Numbness or weakness
- [ ] None of the above

Cardiovascular / Respiratory System

- [ ] Chest pain
- [ ] Dizziness or fainting
- [ ] None of the above
- [ ] Heart racing or palpitations
- [ ] Shortness of breath or wheezing

Gastrointestinal System

- [ ] Nausea or vomiting
- [ ] Constipation
- [ ] Appetite changes
- [ ] Stomachaches
- [ ] Diarrhea
- [ ] None of the above

Endocrine System

- [ ] Heat or cold intolerance
- [ ] Excessive urination
- [ ] None of the above
- [ ] Excessive thirst
- [ ] Menstrual irregularities (teens)

Musculoskeletal System

- [ ] Joint pain
- [ ] Clumsiness or activity intolerance
- [ ] Muscle pain / weakness
- [ ] None of the above

Dermatologic System

- [ ] Rashes / eczema
- [ ] Hair pulling
- [ ] None of the above
- [ ] Chronic skin concerns
- [ ] Skin picking or scratching

Immunological / Allergy System

- [ ] Allergies (food, environmental, medicine, latex)
- [ ] Hives, swelling, itching
- [ ] Frequent infections (ear, strep, colds)
- [ ] Asthma
- [ ] Reactions requiring Benadryl, inhaler, or an EpiPen
- [ ] None of the above

Has your child ever needed medical care or surgery for an illness or injury? ○ Yes ○ No

If yes, please describe

6 | SERVICES

Any history of behavioral health services? Yes No

If yes, please specify type (outpatient counseling, wraparound/IBHS, etc.)

Any current behavioral health services? Yes No

If yes, please specify type (outpatient counseling, wraparound, etc.)

Agency Name Providing the Services

Who Referred Your Child for Evaluation

7 | CONCERNS

Check all that apply.

Family Instability / Trauma / Abuse

- Physical abuse
- Witness of domestic violence
- Foster care
- Neglect
- Parent incarceration
- Sexual abuse
- Witness of parental substance abuse
- Out-of-home placement
- Children/youth services involvement
- None of the above

Any history of parental substance abuse? Yes No

Any history of domestic violence? Yes No

History of the child experiencing any trauma or abuse not listed above? Yes No

If yes, please specify

Signs of Autism

- Speech/language difficulties
- Not wanting to socialize

- [ ] Not knowing how to socialize
- [ ] Lack of imagination/play skills
- [ ] Rocking
- [ ] Echoing others (repeating)
- [ ] Lining-up of objects
- [ ] Fascination with objects and things (fans, trains, lights)
- [ ] Repeating words and phrases from videos (scripting)
- [ ] Extra-sensitive to clothing, sound, food, textures, light
- [ ] Restricted food preferences
- [ ] Poor eye contact
- [ ] Hand-flapping
- [ ] Bouncing/hopping
- [ ] Toe-walking
- [ ] Spinning objects or themselves
- [ ] Obsessing on topics
- [ ] Difficulty with changes in routine or unexpected events
- [ ] Seeks sensory stimulation (bumping into things, wanting firm hugs)
- [ ] None of the above

Behavioral Problems

- [ ] Defiance
- [ ] Back-talk
- [ ] Verbal aggression
- [ ] Attention problems
- [ ] Hyperactivity
- [ ] Difficult community behavior
- [ ] Tantrums
- [ ] Ignoring of direction
- [ ] Physical aggression
- [ ] Destruction of property
- [ ] Impulsivity
- [ ] Deficient grooming and hygiene
- [ ] Tough time doing homework
- [ ] None of the above

Emotional Problems

- [ ] Appears depressed
- [ ] Irritability
- [ ] Obsessive thoughts
- [ ] Sleep problems
- [ ] Self-injurious behavior
- [ ] None of the above
- [ ] Anxiety
- [ ] Compulsions (doing things over and over)
- [ ] Low self-esteem
- [ ] Talk of wanting to hurt self or not be alive
- [ ] Psychiatric hospitalization

Social Problems

- [ ] Difficulty establishing friendships
- [ ] Alienated by peers
- [ ] Withdraws from peers
- [ ] Social phobia (fear of social situations)
- [ ] Difficulty maintaining friendships
- [ ] Arguments with peers
- [ ] Physical confrontations with peers
- [ ] None of the above

School Problems

- [ ] Underachievement
- [ ] Behavior problems in school
- [ ] After-school detentions
- [ ] School refusal
- [ ] Suspensions
- [ ] Threat of expulsion

- [ ] Lunch/recess detentions
- [ ] Problems reading
- [ ] Problems writing
- [ ] Does not turn in homework
- [ ] Does not bring homework home
- [ ] Poor grades
- [ ] Problems with math
- [ ] Leaves homework at home
- [ ] Being bullied
- [ ] None of the above

Food Issues

- [ ] Lack of appetite
- [ ] Over-eating
- [ ] Bingeing (eating large amounts of food in one sitting)
- [ ] Choking/gagging
- [ ] Can't sit through a meal
- [ ] None of the above
- [ ] Finicky
- [ ] Excessive time to eat meals
- [ ] Putting too much food in mouth at once
- [ ] Purging
- [ ] Low-calorie intake

Delinquency

- [ ] Problems with the police
- [ ] Alcohol use
- [ ] Cigarette use / vaping
- [ ] Probation
- [ ] Running away from home
- [ ] Marijuana / drug use
- [ ] Stealing from home/community (stores)
- [ ] None of the above

8 | BIRTH AND EARLY DEVELOPMENT

Any complications during pregnancy/delivery? ○ Yes ○ No

If yes, please explain

Any substances used during the pregnancy? ○ Yes ○ No

Full-term? ○ Yes ○ No

Birth Weight **lbs** **oz**

Born healthy? ○ Yes ○ No

Mom and child discharged together? ○ Yes ○ No

Infant Temperament

○ Calm/Pleasant ○ Fussy

Any serious illnesses during infancy? Yes No

If yes, please explain

Developmental Milestones

Walked independently by one year of age? Yes No

Began expressing words and short phrases by two years of age? Yes No

Toilet trained (urination) on time? Yes No

Toilet trained (bowel movements) on time? Yes No

How old was your child when you first began to have concerns about their behavior/development?

What were your first concerns?

9 | ADDITIONAL INFORMATION

Family Mental Health History

Describe any past or current mental health issues on either side of the family, diagnosed or suspected:

Family Mental Health History

Strengths

Please list some positive things about your child (athletic, good helper, good sense of humor, etc.):

Strengths

Natural Supports

Please list natural supports for your child (extended family, family friends, church family, coach, teacher, etc.):

Natural Supports

10 | STRENGTHS & RESILIENCY INVENTORY (SEARS)

For each statement, select the response that best describes your child's typical behavior.

	Never	Sometimes	Often	Always
Wants to help around the house				
Has an interest in other kids and wants to be around them				
Will approach and interact with other kids				
Other kids seem to think he/she is fun to be around				
Seems to understand the feelings of others				
Seems to care if he/she hurts somebody else's feelings				
Is able to problem-solve to make the situation better				
Is able to admit wrongdoing (to at least some extent)				
Is able to calm down quickly after becoming upset				
Is able to accept reasoning to calm down				

11 | CHILD & ADOLESCENT TRAUMA SCREEN — CAREGIVER FORM (CATS-C)

Child's Name

Stressful or scary events happen to many children. Select YES if it happened to your child (to the best of your knowledge), or NO if it did not happen.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire — Yes / No

2. Serious accident or injury like a car/bike crash, dog bite, or sports injury	Yes	No
3. Robbed by threat, force, or weapon	Yes	No
4. Slapped, punched, or beat up by someone in your family	Yes	No
5. Slapped, punched, or beat up by someone not in your family	Yes	No
6. Seeing someone in the family get slapped, punched, or beat up	Yes	No
7. Seeing someone in the community get slapped, punched, or beat up	Yes	No
8. Someone older touching their private parts when they shouldn't	Yes	No
9. Someone forcing or pressuring sex when they couldn't say no	Yes	No
10. Someone close to the child dying suddenly or violently	Yes	No
11. Attacked, stabbed, shot, or hurt badly	Yes	No
12. Seeing someone attacked, stabbed, shot, hurt badly, or killed	Yes	No
13. Stressful or scary medical procedure	Yes	No
14. Being around war	Yes	No
15. Other stressful or scary events	Yes	No

If other stressful event, please explain

All Done!

Please print this completed form and be sure to bring it with you to your appointment.
We look forward to serving you and your child.