Adolescent Intake Form

Parent/ Guardian to complete pages 1-9
Adolescents aged 13 and older to complete pages 10-17

General Information:

Child's Name:_____

Date of Birth: ___/___/____ Age:_____ Gender: _____

Your Name: _____ Relationship to the Child:_____

Address: _____

_____

Phone Number (Day): _____ Phone Number (Evening):_____

Primary Care Physician: _____

Family Information:

Please list all of the significant parental figures involved in the child's life

Name	Age	Gender	Relationship to the Child	Highest Level of Education	Occupation

Marital Status of the child's biological parents:

Single / Married / Divorced / Remarried / Living Together

If married, date of marriage: _____

If divorced, date of divorce: _____

If biological parents are divorced, who has legal custody of the child?

Please describe the custody arrangements:

Number of previous marriages & length for mother: _____

Number of previous marriages & length for father:_____

Please list all of the child's siblings

Name	Age	Gender	Relationship to the Child	Currently Living in the Home?	Does this child have any behavioral or emotional problems? (Describe)
				YES NO	
				YES NO	
				YES NO	
				YES NO	

Developmental History:

Please list any difficulties that occurred during pregnancy or delivery:

Please describe any concerns related to your child's development:

Health:

Please list all major illnesses, injuries, surgeries, accidents, or other medical conditions that your child has experienced:

Dates	Incident	Treating Physician

Please list all mental health services that your child has received:

Dates	Reason	Therapist/Psychologist

Please list all psychological or psychiatric hospitalizations that your child has been to:

Dates	Reason	Hospital

To your knowledge, has your child ever had any of the following?

Diagnosis or Problem	Yes	No	Person who told you this and their position (eg.,3rd grade teacher, physician). Do not include names.
Aggression	____	____	_____
Alternating Mania and Depression (Bipolar)	____	____	_____
Anxiety	____	____	_____
Attention Deficit Hyperactivity Disorder	____	____	_____
Autism	____	____	_____
Behavior or Discipline Problems at Home	____	____	_____
Behavior or Discipline Problems at School	____	____	_____
Conduct Disorder	____	____	_____
Depression	____	____	_____
Emotional Disturbance	____	____	_____
Hospitalized for Emotional Problems	____	____	_____
Jail or Probation Due to Problems w/ the Law	____	____	_____
Learning Disability or Dyslexia	____	____	_____
Learning Problems at School	____	____	_____
Mental Retardation	____	____	_____
Muscle Twitches or Motor Tics	____	____	_____
Nervous Breakdown	____	____	_____
Obsessive Thoughts or Compulsive Actions	____	____	_____
Oppositional Defiant Disorder	____	____	_____
Problems with Alcohol Use or Abuse	____	____	_____
Problems with Drug Use or Abuse	____	____	_____
Schizophrenia	____	____	_____
Suicide	____	____	_____
Tourette's Syndrome	____	____	_____
Trouble with the Law	____	____	_____
Other Psychological / Behavioral Problems*	____	____	_____

Please list any prescription medications that your child is currently taking:

Medication	Dosage	Reason Taken	# of times of day taken	# of days a week taken	Prescribing Physician
				School days 7 days As needed	
				School days 7 days As needed	
				School days 7 days As needed	
				School days 7 days As needed	

Please describe your child's medication compliance:

Please describe any side effects from the medications:

Education:

School Name:_____

Your child's current grade in school: _____ Typical Grades: _____

Has your child ever been held back in school?

If so, please describe the circumstances:

Has your child ever been suspended or expelled?

If so, please describe the circumstances:

Has your child ever been tested for intellectual ability or had any other psychological testing?

If so, what was the most recent date of testing:

Please describe the results:

Does your child have a 504 Plan?

If so, please describe the nature of the accommodations:

Does your child receive special education services?

If so, please describe the nature of the services received:

Does your child's teacher have concerns about your child?

If so, please describe:

Is your child currently participating in a school/classroom intervention?

If so, please describe:

Please list any concerns that you have for your child related to school:

Current Reasons for Seeking Treatment:

Please describe the reasons that you are seeking treatment for your child at this time:

Please briefly describe the history of these concerns and list all factors that may trigger or intensify these concerns:

Please list the things that you have tried/ done to help your child:

Please describe your child's strengths:

Instructions: In the spaces below complete the rating at the end of each by marking an "X" on the lines at the points that describe how much your current challenges affect each area and *whether you need treatment or special services for the challenges.*

1a. How your **child's challenges** affect your relationship with friends.

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

1b. How your **child's challenges** affect his or her relationship with brothers or sisters (if no siblings, check here _____ and skip to #2)

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

2. How your **child's challenges** affect your relationship with your parent(s).

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

3. How your **child's challenges** affect your academic progress at school

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

4. How your **child's challenges** affect your self-esteem

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

5. How your **child's challenges** affect your family in general

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

6. Overall severity of your **child's challenges** in functioning and overall need for treatment.

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services