Intake Assessment
Child/Adolescent

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits.

Information supplied by: Relationship ____________________________

Child's Name: ____

Why is the child coming to counseling? ____

____

____

How long has this problem persisted? ____

Under what conditions do the problems usually get worse and under what conditions are the problems usually improved?

____

____

Desired outcome or expectations of treatment (changes you would like to make, how we can help)? _________________

____

Has the child been involved in previous counseling? _____Yes _____ No

If Yes, please describe: ____

____

Strengths/Concerns

Briefly describe the child's greatest strengths: ____

____

____

Briefly describe the child's likes and dislikes (including hobbies and interests): _________________________________

____

____

Briefly describe the child's main difficulties at home:____

____

____

Briefly describe the child's difficulties with peers: ____

____

____

Briefly describe the child's friendships:____

____

Medical

Physician's Name: ____

Most Recent Physical Exam: ___________________________________ Results: ___________________________

Height: _______ Weight: _________

Are your child's immunizations up to date? ___________________

Most Recent Dental Exam: ____________________________

Any known allergies:____

List any past or present illnesses, operations, or conditions: ____

____

List any present physical concerns (e.g., dizziness, headaches, stomach aches, etc.):________________________________
____
____

On average how many hours of sleep does the child receive daily? ____

Does the child have trouble falling asleep at night? _____Yes _____ No

If Yes, how long has this been a problem? ____

Describe the child's appetite (during the past week):___ poor appetite ___ average appetite ___ large appetite

Have there been any recent changes in appetite or sleep? If Yes, please describe: _______________________________
____

What medications (and dosages) are being taken at present, and for what purpose? ________________________________
____
____

Developmental History

Information unknown due to:____

Information regarding pregnancy and delivery:

Was the pregnancy planned? _____Yes _____No _____ Unknown

Was prenatal care received? _____Yes _____No _____ Unknown

Did the pregnancy go full term? _____Yes _____No _____ Unknown

Was delivery by cesarean section? _____Yes _____No _____ Unknown

Were there complications with pregnancy or delivery? If Yes, please describe: ___________________________________
____
____

Substances used by mother or father at time of conception, or by mother during pregnancy (check all that apply)

Father: _____Alcohol _____Marijuana _____Cocaine/crack _____Other ____ None _____ Unknown

Mother: _____Alcohol _____Marijuana _____Cocaine/crack _____Other ____ None _____ Unknown

Please fill in when the following developmental milestones took place:

Behavior	Age began	Unknown	Comments
Walking	________	_______	______________________________
Talking	________	_______	______________________________
Toilet trained	________	_______	______________________________

Please rate your opinion of the child's current development (compared to others the same age) in the following areas. For any identified as below average, please describe:

	Above Average	About Average	Below Average	Describe
Social	____	____	____	______________________________
Physical	____	____	____	______________________________
Language	____	____	____	______________________________
Intellectual	____	____	____	______________________________
Emotional	____	____	____	______________________________

Education

School attending:____________________________________ Year in school: ____________________________

Is the child receiving special education services? ____Yes _____ No

If Yes, circle category, if known: ASD CI ECDD EI HI PI OHI SXI SLD SLI TBI VI DB

How does your child typically perform academically? ____
____

Has this changed lately? _____Yes _____No If Yes, how? ____

____

Briefly describe any school difficulties: ____

____

Current Family Information

What is the family structure? Check all that apply:

_____Single parent mother _____Single parent father _____Parents unmarried

_____Parents married, together _____Parents divorced _____Parents separated

_____With mother and stepfather _____With father and stepmother _____Grandparents

_____Child adopted _____Other, describe____

Mother's age: _______ If deceased, how old was the child when she passed away? ________________________

Father's age: _______ If deceased, how old was the child when he passed away? ________________________

If parents are separated or divorced, how old was the child then? ____

Number of brother(s) _____ Their ages _____ _____ _____ _____ _____ _____ _____

Number of sister(s) _____ Their ages _____ _____ _____ _____ _____ _____ _____

Child number _______ in a family of _________ children.

Briefly describe the child's relationship with brothers and/or sisters:

Biological siblings: ____

____

Step and/or half siblings: ____

____

Other: ____

____

If child is being raised by a caregiver other than biological parent, please describe the situation:

____

____

Parents' occupations: Mother ________________________________ Father____

Who provides care for child when the caregiver is absent? ____

Briefly describe the type of parenting used in the household: ____

____

____

How, and for what reason, is the child disciplined? ____

____

Trauma History

Is there a history or recent occurrence(s) of child abuse to this child? _____Yes _____No

If Yes, which type(s): _____Verbal _____Physical _____Sexual _____Emotional _____Neglect

Please describe: ____

____

____

Has there ever been a time when you wondered about abuse occurring? _____ Yes _____ No

If Yes, please describe:____

____

Has there ever been a time when Child Protective Services has been involved in the life of this child or its family?

_____Yes _____No If Yes, please describe: ____

____

Have there been any other traumas experienced by this child? If Yes, please describe the situation. (ex. scary medical procedures, prenatal stressors, prenatal exposure to substances, accidents, grief and loss, witnessing, experiencing or exposure to violence, natural disasters, any life threatening situation):____

____

____

Religion

How important to your child are spiritual matters? ____ Not at all ____ Somewhat _____Very Much
Is your child and/or family affiliated with a spiritual or religious group? ____Yes ____ No
If Yes, please describe: ____

____

Would you and/or your child like your spiritual/religious beliefs incorporated into counseling sessions? ___ Yes ___ No
If Yes, please describe: ____

____

Cultural/Ethnicity

To which cultural and/or ethnic group do you and/or child belong?______________________________
Are you and/or your child experiencing any problems due to cultural or ethnic issues? ____ Yes ____ No
If Yes, please describe:____

____

Would you and/or your child like cultural/ethnic practices incorporated into your counseling sessions? ____ Yes ____ No
If Yes, please describe: ____

____

Substance Use History

Personal and Family substance use, past and present

	Client Information						Family Information
	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours	Used in last 30 days	Use in immediate or extended family?
					Yes/No	Yes/No	Yes*/No
Alcohol							
Marijuana							
Caffeine							
Nicotine							
Other drugs							

*If Yes, Please describe immediate and extended family substance use: ______________________________

____

____

______________________________ ______________________________
Therapist Signature Date Reviewed with Client(s)