Child and Adolescent Intake Form

Child's Name_____ Age: _____ Date of Birth: _____

Address: _____City, State, Zip:_____

School: _____ Grade: _____

Person accompanying child: _____ Relationship: _____

Child lives with: (Circle one)

Both parents Mother Father Mother/Stepfather Father/Stepmother Other

Mother's Name: _____ Father's Name:_____

Address: _____ Address: _____

_____ _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell; Phone: _____

Employer: _____ Employer: _____

Spouse's Name: _____ Spouse's Name: _____

I give Dr. Stone permission to leave messages via: ___text ____email ____voicemail

Child's Physician: _____ Date of last visit: _____

Please list any significant health problems your child is experiencing: _____

_____

Please list any medications your child is taking and who prescribed them:

_____

Has your child had counseling previously? If yes, when and with whom?

_____

What is your child's religious affiliation? _____

What are the reasons your child is coming into counseling at this time?

What changes do you hope to see as a result of counseling?

Circle all the behaviors and symptoms you consider to be problematic in your child's life right now:

Worrying	Sadness	Religious/spiritual concerns
Panic attacks	Hopelessness	Difficulty making decisions
Social discomfort	Crying easily	Family problems
Racing heart	Fatigue	Disturbing memories
Poor appetite	Feeling inferior	Bad dreams
Headaches	Poor concentration	Loss of interest in things
Sleep disturbance	Poor memory	Thoughts of harm to others
Obsessive thoughts	Health concerns	Thoughts of death
Feeling fearful	Friend relationships	Self-harm behaviors
Outburst of temper	Irritability/anger	Alcohol/drug use

Has your child ever experienced any sort of trauma? _____

_____

Is there a history of mental health problems in your family? Which family members?

_____

Are they currently taking any medications to treat these problems? _____

How did you get referred to Dr. Stone? _____

If appropriate, may Dr. Stone communicate with your referral source to let them know you have followed up on their recommendation for services? If so, please sign below.

_____ _____

Name Date