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Child/Adolescent Intake Form to be completed by Parent

To be completed by parent or guardian requesting services for a minor child. This information will help your counselor understand your child. As with all communications with your therapist, it will be kept confidential to the full extent of Georgia law.

Today's Date: __________
Name of person filling out intake___________________ Relationship_____________________
How did you hear about us?____

Identifying/Contact Information

Child's Name:____

Date of Birth:___________Sex: _______Grade in School____________

Child's Full
Address:____
Home phone:________________Who does Child lives with? ____________________________

If parents are divorced, describe custody arrangements:_______________________________
____

Information about child's mother Name:____
Address: Same_____If different:____
Contact phone________________________
Occupation:___________________________Employer:_______________________________

Informatione about father Name____
Address: Same:________If different____
Contact Number ______________________
Occupation:___________________________Employer:_______________________________

Other Family Members

Please list child's siblings, including any step siblings, in birth order and their ages. Indicate where child falls in birth order. Specify if sibling living with child now.

Child's Name Age Living in home now?
____
____
____
____
____

List other family members that live in household and their relationship to child:
____
____
____

Developmental History

Were there any complications surrounding the child's birth? Yes_____ No____
If yes, please describe ____
____

Were developmental milestones normal? (walking, talking, toilet training)

Yes___ No___ If no, then please describe_______________________________________
____
____
____
List child's sicknesses, operations, and injuries. Indicate age when occurred and describe severity. Pay special attention to head injuries and any time your child was unconscious, had convulsions, a high fever or hospitalization:_____________________________________
____

List current medical problems
____
____
____
List any current any prescription medications presently taking:

Name of drug Dosage For what condition? Prescribing physician
____
____
____
____
When was your child's last physical exam?______________________________________
Name of primary care physician____

Academic/school Information

Name of School child attends____

Grade________Teacher____________________County_____________________________
Has child ever repeated a grade?____Which one? ___________________ What kind of grades does your child get?__________________________Does child have any learning difficulties? If so, please specify ____
____
____

Describe your child's behavior at school____
____

Describe your child's personality at school (example: shy, outgoing, friendly, active)__________
____
____

How easily does your child make friends?____

How does your child's teacher describe your child?______________________________________
____

What kinds of extracurricular activities does your child participate in? ______________________
____

Describe what your child likes to do for fun at home_____________________________________
____

Counseling Concerns

Describe briefly the problem which prompted you to seek counseling for your child at this time:
____
____
____
____

When did the problem appear?____
____

Describe times when the problem got better or disappeared?_________________________________
____

What do you think helped?____

Describe times when the problem has been especially bad?__________________________________
____
____

Who are any other people who play a major role in causing this problem, or in helping the child or you cope with the problem?____
____
____

What else you would like your counselor to know at this time?_____________________________
____
____

Scale of Current Concerns

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item. You may add written comments if you wish.

0 1 2 3	4 5 6	7 8 9 10
No concern	Moderate concern	Extreme concern

Anger/temper ____ Behavioral acting out______

Depression _____ Talk of suicide____________

Divorce/separation of parents _____ Unhappy a lot_____________

Adjustment to parent's remarriage _____Use of alcohol_____________

School performance_______ Use of drugs______________

Family problems _____ Work____________________

Fearfulness _____ low confidence____________

Physical problems _____ poor appetite______________

Problems with social relationships _____Overeating________________

Problems sleeping _____ Bedwetting________________

Nightmares________ Soiling___________________

Sexual concerns _____ Cruelty to animals__________

Religious/spiritual concerns _____ Fire setting_______________

Other problems:____
____
____

Has your child had any previous counseling? If yes, For what, where and by whom?
____
____