

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

 / /

Child's First Name

Child's Last Name

Date of Birth

 / /

Age

Sex

☐ Male ☐ Female ☐ Prefer not to disclose

Eye Color

Ethnicity

Height

Weight

Physical Address

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)** / / **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 | ☐ Notable fatigue or low energy |
| ☐ Unusually high energy | ☐ Frequent illnesses or fevers |
| ☐ Prolonged high fever | ☐ Serious medical conditions |
| ☐ Visual deficits | ☐ Corrective lenses |
| ☐ Hearing deficits | ☐ Hearing aides |
| ☐ None of the above | |

Sleep System

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

Neurological System

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

Cardiovascular / Respiratory System

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

Gastrointestinal System

- | | |
|---|--|
| ☐ Nausea or vomiting | ☐ Stomachaches |
| ☐ Constipation | ☐ Diarrhea |
| ☐ Appetite changes | ☐ None of the above |

Endocrine System

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

Musculoskeletal System

- | | |
|---|---|
| ☐ Joint pain | ☐ Muscle pain / weakness |
| ☐ Clumsiness or activity intolerance | ☐ None of the above |

Dermatologic System

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

Immunological / Allergy System

- | | |
|---|--|
| ☐ Allergies (food, environmental, medicine, latex) | ☐ Asthma |
| ☐ Hives, swelling, itching | ☐ Reactions requiring Benadryl, inhaler, or an EpiPen |
| ☐ Frequent infections (ear, strep, colds) | ☐ 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 | ☐ Sexual abuse |
| ☐ Witness of domestic violence | ☐ Witness of parental substance abuse |
| ☐ Foster care | ☐ Out-of-home placement |
| ☐ Neglect | ☐ Children/youth services involvement |
| ☐ Parent incarceration | ☐ 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

Behavioral Problems

- ☐ Defiance
- ☐ Back-talk
- ☐ Verbal aggression
- ☐ Attention problems
- ☐ Hyperactivity
- ☐ Difficult community behavior
- ☐ Tantrums

Emotional Problems

- ☐ Appears depressed
- ☐ Irritability
- ☐ Obsessive thoughts
- ☐ Sleep problems
- ☐ Self-injurious behavior
- ☐ None of the above

Social Problems

- ☐ Difficulty establishing friendships
- ☐ Alienated by peers
- ☐ Withdraws from peers
- ☐ Social phobia (fear of social situations)

School Problems

- ☐ Underachievement
- ☐ Behavior problems in school
- ☐ After-school detentions

- ☐ 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

- ☐ Ignoring of direction
- ☐ Physical aggression
- ☐ Destruction of property
- ☐ Impulsivity
- ☐ Deficient grooming and hygiene
- ☐ Tough time doing homework
- ☐ 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

- ☐ Difficulty maintaining friendships
- ☐ Arguments with peers
- ☐ Physical confrontations with peers
- ☐ None of the above

- ☐ 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.