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Child and Adolescent Psychotherapist

CLIENT INFORMATION & INTAKE FORM

Date of first appointment:_____

Please take your time in providing the following information. The questions are designed to help me begin to understand your child so that our time together can be as productive as possible. All information provided is confidential.

Client Name:_____

Date of Birth:_____ Age:_____ Gender:____

Parent(s)/Legal Guardian(s) Name(s):_____

Address:_____

Client Cell:_____ Home Phone:_____

Parent(s)/Guardian(s) Cell:_____

Emergency Contact:_____

Client Email:_____

Parent(s)/Guardian(s) Email:_____

May I leave a voicemail? _____ May I send you email?_____

Nation/Tribe/Ethnicity:_____ Primary Language:_____

School:_____

Referred by:

- ☐ Medical Provider: _____
- ☐ School
- ☐ My Website: mindfullymecounseling.com
- ☐ PsychologyToday
- ☐ Friend/Family: _____
- ☐ Other: _____

Has your child previously received any type of mental health services?

- ☐ Yes
- ☐ No

If yes, which of the following:

- ☐ Psychotherapy
  Previous Therapist Name:_____
- ☐ Medication
  Please list medications:_____
- ☐ Outpatient Hospitalizations

- ☐ Inpatient Hospitalization
  Name of provider or facility:_____

  Location:_____

  Dates of treatment:_____

  Reason for treatment:_____

Briefly, what brings you in today:

When did your child's problem first start?

What areas of you and/or your child's life have been affected because of this problem?

Is your child currently experiencing overwhelming sadness, grief or depression?

- ☐ Yes
- ☐ No

If yes, for approximately how long? _____

Is your child currently experiencing anxiety, panic attacks or have any phobias?

- ☐ Yes
- ☐ No

If yes, when did they begin experiencing this? _____

Please describe any major losses or traumatic events your child may have experienced and at what age.

What significant life changes or stressful events has your child experienced and at what age?

What would you like your child to accomplish in therapy?

Family History

Where was your child born? _____

- ☐ City
- ☐ Suburbs
- ☐ Country

Please describe your experience during pregnancy and at birth? If your child is adopted, please provide any information you may have regarding their in utero or perinatal experience.

Have there been any moves in your child's life? If yes, please list the move and age of your child at the time.

Please list your child's primary caregivers and siblings. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Has anyone else lived in the home? If so, who? _____

Parent(s)/Guardian(s) occupations: _____

In the section below please mark if there is a family history of any of the following conditions. If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.).

✔	Condition	Family Member
	Alcohol/Substance Abuse	
	Anxiety	
	Depression	
	Domestic Violence	
	Sexual Abuse	
	Eating Disorder	
	Obesity	
	Obsessive Compulsive Disorder	
	Schizophrenia	
	Suicide Attempt/Completion	
	ADD/ADHD or other Learning Disorders	
	Incarceration	
	Social Services Involvement	
	Other Diagnosis:_____	

Parent(s)/Guardian(s) Marital Status:

- ☐ Never Married
- ☐ Domestic Partner
- ☐ Married
  For how long?_____
- ☐ Separated
- ☐ Divorced
  For how long?_____
- ☐ Widowed
  Please provide your partners name and year deceased:_____

<u>Parent(s)/Guardian(s):</u>

If separated, divorced, or widowed, are you currently in a romantic relationship?

- ☐ Yes
  How long? _____
- ☐ No

If yes, or married or in a domestic partnership, on a scale of 1-10 (best), how would you rate your relationship? _____

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If your child has a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of their health.

Medication/Supplement	Dosage	Condition	Dates Began/Stopped

Prescribing provider and contact information:
Name: _____

Specialty: _____

Facility: _____

Phone, Email, or Fax: _____

How would you rate your child's current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

Please list any specific health problems your child is currently experiencing:_____

_____

How would you rate your child's current sleeping habits?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

If your child is having problems with sleep, in which phase of sleep are they experiencing issues?

- ☐ Falling asleep
- ☐ Staying asleep
- ☐ Awakening early
- ☐ Sleep apnea

Please list any other specific sleep problems your child is currently experiencing:_____
_____

How is your child's appetite?
☐ Good
☐ Fair
☐ Poor

Is your child having any problems related to eating or food? Please describe:

Please describe how your child is doing in school (grades, participation, peer relationships, etc.).

Has your child ever been suspended or expelled from school? Please describe:

Please list any after school activities your child participates in.

Please describe how your child does in these activities.

Is your family involved in any religious or spiritual community?

Are there any other symptoms, behaviors, or history you think I should know?