Connie L Clark, LCPC, NCC, CGRS, SEP **Child/Adolescent Intake Form:**

Please fill out this biographical background form as completely as possible in order to help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the next session if you do not complete it today while waiting for your child.

Information supplied by: _____

Relationship: _____ Today's Date: _____

PLEASE PRINT:

1) Client's Name: ___2] Age: _____
3] Date of Birth: _____4] Gender: _____5] Height: _____
6] Weight: _____7] Eye Color: _____8] Hair Color: _____ 9] Race: _____

10] Address:_____
City: _____ State: _____ Zip: _____
11] Home phone: _____ Cell phone: _____
12] School: _____ Year: _____

13) Has the child been involved in previous counseling? If yes, please describe:
_____
_____

14) Why is the child coming to counseling?
_____
_____

15) How long has this problem persisted (from # 14)?
_____

16) Under what conditions do the problems usually get worse?
_____
_____

17) Under what conditions are the problems usually improved?
_____
_____

18] Reasons for seeking therapy:

Reason:	**Yes or No**	**Reason:**	**Yes or No**
Reactive Attachment Disorder	_____	Attachment Ruptures	_____
Developmental Trauma	_____	Medical Trauma	_____
Single Incident Trauma	_____	Shock Trauma	_____

Parenting Issues	_____	Sleep Disturbance	_____
Post Traumatic Stress Disorder	_____	ADD/ADHD	_____
Mother / Child Attachment	_____	Depression/Mood Disorders	_____
Personality Disorders	_____	Anxiety	_____
Fear / Phobia	_____	Nightmares/Night Terrors	_____
School Issues	_____	Addictive Behaviors	_____
Oppositional Defiant	_____	Other: _____	_____

Medical History

1) Name and address of your primary physician:
Physician's name: _____
Address: _____ City: _____ State: ____ Zip: _____
Most recent physical exam: _____
Results:_____

2) Dental: Most recent exam: _____
Results: _____

3) Vision: Most recent exam: _____
Results: _____

4) Hearing: Most recent exam: _____
Results: _____

5) Current prescribed medications:
a]_____ Dose _____
Purpose _____Side effects_____
b]_____ Dose _____
Purpose _____Side effects_____
c]_____Dose _____ _____
Purpose _____Side effects_____

6) Current over-the-counter meds
a]_____ Dose _____
Purpose_____ Side effects_____
b]_____Dose_____
Purpose_____ Side effects_____
c] _____ Dose _____
Purpose _____ Side effects _____

7) Immunization record (check immunizations the child/adolescent has received) prior to school:
_____DPT Polio: Age [s] received: _____ _____ _____

_____Rubella: ____4 months ____6 months ____18 months ____4-5 years

_____ MMR (Measles, Mumps); age[:] received:_____

____ HBPV (Hib): age received: _____

_____HepB : age received: _____

8] List any major illnesses and/or operations your child has had:
_____
_____

9] List any physical concerns occurring at present: (e.g., high blood pressure, headaches, and dizziness):
_____

10) List any physical concerns (e.g., head trauma, seizures) experienced in the past:
_____
_____

11) On average how many hours does the child sleep daily? _____

12] Does the child have trouble falling asleep at night? ___Yes ___No

If yes, how long has this been a problem? _____

13] Describe the child's appetite (during the past week):

_____ Poor appetite _____ average appetite _____ large appetite

Medical History (check all that apply):

__Abortion	__ Hay fever	__Pneumonia
__Asthma	__ Heart trouble	__Polio
__Blackouts	__ Hepatitis	__ Pregnancy
__ Bronchitis	__ Hives	__ Rheumatic Fever
__ Cerebral Palsy	__ Influenza	__ Scarlet Fever
__ Chicken Pox	__ Lead poisoning	__ Seizures
__ congenital problems	__ Measles	__ severe colds
__ Croup	__ Meningitis	__ severe head injury
__ Diabetes	__ Miscarriage	__ sexually transmitted disease

__ Diphtheria	__ Multiple sclerosis	__ Thyroid disorders
__ Dizziness	__ Mumps	__ Vision problems
__ Ear infections	__ Muscular Dystrophy	__ Wearing glasses
__ Eczema	__ Nose bleeds	__ Whooping cough
__ Encephalitis	__ other skin rashes	__ Fevers
__ Pleurisy	__ Paralysis	__ other

Chemical Use History

1) Does the child/adolescent use or have a problem with alcohol or drugs? __ Yes ___No
If yes, describe:
_____
_____

Family History

1) With whom does the child live at this time? _____

2) Is the child adopted or raised with parents other than biological parents? __ Yes __ No

3) Are parents divorced or separated? _____

4) If parents separated or divorced, how old was the child then? _____

5) If divorced, who has legal custody?

___Single parent, mother unmarried
_____Single parent, father unmarried
____Parents Married
_____Parents Married but separated
____Parents Divorced
_____Lives with mother and step- father
_____Lives with father and step- mother
_____ Lives with relatives
_____Adopted
_____Foster care

6) Is there any significant information about the parents' relationship or treatment toward the child, which might be beneficial in counseling? ___ Yes ___ No
If yes, describe:
_____
_____

7) What is the family relationship between the child and his/her custodial parents?
_____
_____

8) Is there a history of recent occurrence(s) of child abuse to this child? __ Yes __ No
If yes, which type(s) of abuse? __ Verbal __ Physical __ Sexual

Comments [regarding #8]:
_____
_____

Client's Parent 1
Name: _____ Age: _____
Occupation: _____ _____FT ___ PT
Where employed: _____Work phone: _____
Parent 1 Education:_____

Is there anything notable, unusual or stressful about the child's relationship with Parent1?
___ Yes __ No If Yes, please explain:
_____
_____

How is the child disciplined by Parent 1?
_____
_____

For what reasons is the child disciplined by Parent 1?
_____
_____

Client's Parent 2
Name: _____ Age: _____
Occupation: _____ ___FT ___PT
Where employed: _____ Work phone: _____
Parent 2 education: _____

Is there anything notable, unusual or stressful about the child's relationship with Parent 2? ___ Yes ___ No If Yes, please explain:
_____
_____

How is the child disciplined by Parent 2?
_____
_____

For what reasons is the child disciplined by Parent 2?
_____
_____

Client's Siblings and Others who live in the Household:

Names of Sibling	Age	Gender	Bio/Adopt
1 _____	_____	_____	_____

2 _____ _____ _____ _____
3 _____ _____ _____ _____
4 _____ _____ _____ _____
5 _____ _____ _____ _____

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

Step/half siblings:
_____
_____

Adoptive siblings:
_____
_____

A DAY IN THE LIFE OF YOUR CHILD

Please write a description of a typical day in your child's life. Please include the following information and anything else that you think might assist in the treatment your child:

1] Describe your child's typical behaviors.

2] Describe how you would typically respond to these behaviors.

3] Describe the interaction between your child and siblings.

4] Which of your child's behaviors bothers you the most?

5] Discuss your child's positive attributes and interests.

6] Describe your child's school behavior and your child's response to authority.

7] Describe the community's (teachers, neighbors, friends, family) reactions to your child's behavior and to your parenting interventions.

8] Describe how your child relates to mother and father.

9] Describe what impact this child has had:

a] On your marriage:

b] On your family

c] On your lifestyle

d] On personal well being.

10] Which of your parenting techniques seems to be the most effective?

11] Which of your parenting techniques seems to be the most ineffective?

12] What have you tried?

13] Does anyone in your family feel physically threatened?

14] What are your worst fears?

15] What are your best hopes?

Current Family:

1] Describe your current marriage/relationship (include both strengths and weaknesses).

2] Give a brief description of any previous marriage(s).

3] Describe your parenting philosophy.

4] Describe your means of motivation/discipline.

5] Describe any differences of parenting styles.

6] Describe your communication styles.

7] How are decisions made?

8] Describe any current significant medical problems you, or other family members are dealing with.

9] What concerns do you have with any other family member?

10] Describe the family's support system.

11] Describe your family's involvement with outside activities.

12] How large of a role (if any) does religion play in your family?

13] Describe your family's lifestyle.

_____

Parent/Guardian Signature Date

If you have any additional information you would like to share, Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation.

Thank you for completely this detailed information packet. It is helpful for me to have a sense of your child's relationship to her/his parents and other significant people in her/his life. Also, please note that I will also want to meet with you individually to discuss in person your concerns for your child and the goals you have for her/his treatment. Also, please recognize that your child, as my client, has rights and my role as the therapist, in working with your child is to develop a therapeutic alliance that supports your child's healing. However, that being said, please fell free to contact me to give updates regarding your child's behaviors and coping strategies that may be helpful in my work with your child. I encourage parent input in a manner that can benefit the child's healing process.

Again, thank you for putting your trust in me to work with your child.

Connie L. Clark, LCPC, NCC, CGRS, SEP

Additional Comments Page: Please feel free to share any additional comments such as Goals you may have for your child [though recognize they may be different than the child's goals], Hopes, concerns, etc. that were not addressed/covered in the questionnaire