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CHILD & ADOLESCENT INTAKE FORM

Date of Intake: ______________________

Child's Name: ____________________________________ Date of Birth: ______________

Address: ____

Age: _____ School: ____________________________________ Phone: ______________

Teacher: ____ Grade: _______

Names of Parents: ____

Best way to reach you (phone, email, etc.): _____________________________________

1. REASON FOR REFERRAL

Who referred you?

____

What do you perceive the problem to be?

____

2. BACKGROUND INFORMATION

A. General Background History

Name of Mother: ____

Education: ____

Profession: ____

Name of Father: ____

Education: ____

Profession: ____

List family members (siblings, other(s) living with child):

____

Relationship to child (age, gender, etc.): ____________________________

B. Other Pertinent Background History

Parents' marital status? ______________________________________

If parents are not married, then:

Do you have a significant other? ________________________________

Does s/he live with the family? _________________________________

How do(es) the child(ren) get along with him/her?

____

If parents divorced or widowed:

When (how old was the child)? _________________________________

Who has custody of the child? _________________________________

Relationship with non-custodial parent: (How often does your child see him/her?)

____

C. Developmental History

Pregnancy with child:

____

Delivery and perinatal complications, if any?:

____

How was your child as a baby?

____

Developmental Milestones: (comment on any problems)

1. Motor _______________________________________

2. Language _____________________________________

D. Medical History

1. Hospitalizations?

____

2. Chronic Illnesses (e.g. asthma, diabetes, allergies, etc.)?

____

3. Allergies? ______________________________

4. Other illnesses? ______________________________

5. Accidents? If so, when and what happened?

____

Loss of consciousness? ______________ For how long? ______________

Medication History (past and present):

____

E. School Information

How does your child do in school academically?

____

What are your child's grades? ______________________________

Special placement in school? ______________________________

Has your child been evaluated in the past? ______________________________

Reason for evaluation:

____

How does your child do in school behaviorally?

____

Does your child have a learning or physical disability? Yes No Maybe

Please specify: ______________________________

Does your child have a mental health diagnosis? Yes No

Please specify: ______________________________

F. Social Life

1. Does your child have many friends?

____

2. Does your child have problems socially? Please describe:

____

3. What kind of activities does your child do with her/his friends?

____

4. How does s/he get along with other children at school?

____

5. What does your child do for fun? (activities, hobbies, sports, etc.)

____

G. Other Relevant Information

Additional information that could help me understand your child better:

____

Briefly describe your goals for your child's therapy:

Thank you for taking the time to fill out this form

Caitlin R. Burgess, JD, MA, LMFT