

Teen/Child Intake Form

Date: _____

Client Name: _____

DOB: _____

Person completing form (e.g., parent/guardian): _____

Relationship: _____

If you are unable to answer any of the questions below, please write DK (Don't Know) in the blank provided.

ETHNICITY (optional):

___ Caucasian ___ Hispanic ___ Asian ___ Other: _____
___ African American ___ Native American ___ Bi/Multiracial _____

HOUSEHOLD

Intimate Relationship

___ never been in a serious relationship
___ not currently in serious relationship
___ currently in a serious relationship
___ not currently looking for serious relationship

Relationship Satisfaction

___ very satisfied ___ very dissatisfied
___ satisfied ___ dissatisfied
___ somewhat satisfied

List all persons currently living in child's household

Name	Age	Sex	Relationship to child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List children and stepchildren not living with child

Name	Age	Sex	Freq of visit/Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any past or current significant issues in intimate relationships:

HISTORY

FAMILY OF ORIGIN

Present during Childhood:

	Present entire childhood:	Present part of childhood:	Not present at all:
Mother	[]	[]	[]
Father	[]	[]	[]
Stepmother	[]	[]	[]
Stepfather	[]	[]	[]
Brother(s)	[]	[]	[]
Sister(s)	[]	[]	[]
Other: _____	[]	[]	[]

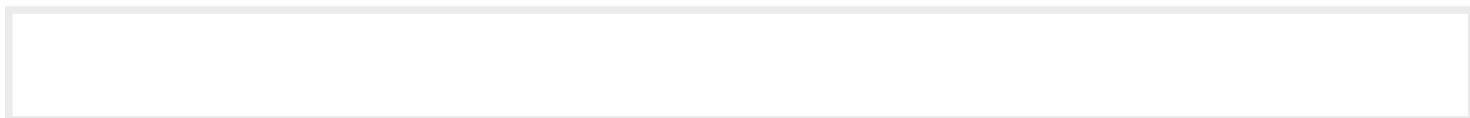
Parent's current marital status:

[] Married to each other for ___ years
[] Separated for ___ years
[] Divorced for ___ years
[] Mother remarried ___ times
[] Father remarried ___ times
[] Mother involved with someone
[] Father involved with someone
[] Mother deceased for ___ years
 (your age at mother's death: ___)
[] Father deceased for ___ years
 (your age at father's death: ___)

Describe parents:

Father: [] biological [] adoptive [] step [] other
Full name: _____
Occupation: _____
Education: _____
General health: _____

Mother: [] biological [] adoptive [] step [] other
Full name: _____
Occupation: _____
Education: _____
General health: _____



Describe child's family experience:

- | | | |
|---|---|---|
| <input type="checkbox"/> outstanding home environment | <input type="checkbox"/> poverty (serious financial problems) | <input type="checkbox"/> experienced physical/verbal/sexual abuse from others (circle all that apply) |
| <input type="checkbox"/> normal home environment | <input type="checkbox"/> witnessed or was aware of physical/verbal/sexual abuse (circle all that apply) | |
| <input type="checkbox"/> chaotic home environment | | |
| <input type="checkbox"/> alcoholic/addicted parent(s) | | |

Describe any abuse the child has experienced: _____

Other difficult experiences the child has had: _____

Age of emancipation from home: _____ *Circumstances:* _____

Describe any past or current significant issues in other immediate family relationships: _____

DEVELOPMENTAL HISTORY (check all that apply to child's development)

Problems during mother's pregnancy:

- none
- high blood pressure
- bed rest
- alcohol use
- drug use
- cigarette use
- other _____

Birth:

- normal delivery
- difficult delivery
- cesarean delivery
- complications: _____

Infancy:

- feeding problems
- sleep problems
- toilet training problems
- colic
- other: _____

Birth weight: _____

Childhood health:

- lead poisoning (age: ____)
- ear infections
- head injury (list age and describe: _____)
- other significant injury (list age and describe: _____)
- asthma (age diagnosed _____)
- seizures (type and ages: _____)

- hearing loss (age diagnosed and severity: _____)
- impaired vision not corrected by lenses (age diagnosed: _____)
- surgeries (ages and type: _____)
- chronic, serious health problems: _____

Delayed developmental milestones (check only those that were not reached at expected age):

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> sitting | <input type="checkbox"/> engaging peers | <input type="checkbox"/> walking |
| <input type="checkbox"/> rolling over | <input type="checkbox"/> tolerating separation | <input type="checkbox"/> speaking |
| <input type="checkbox"/> standing | <input type="checkbox"/> toilet training | <input type="checkbox"/> riding bicycle |

Social interaction (check all that apply to child):

- | | |
|--|---|
| <input type="checkbox"/> normal social interaction | <input type="checkbox"/> isolated self |
| <input type="checkbox"/> very shy | <input type="checkbox"/> dominated others |
| <input type="checkbox"/> inappropriate sex play | <input type="checkbox"/> had acting out friends |
| <input type="checkbox"/> other: _____ | |

Emotional/behavior problems (check all that apply to child):

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> drug use | <input type="checkbox"/> disobedient | <input type="checkbox"/> immature | <input type="checkbox"/> anxious |
| <input type="checkbox"/> alcohol abuse | <input type="checkbox"/> distrustful | <input type="checkbox"/> hyperactive | <input type="checkbox"/> easily distracted |
| <input type="checkbox"/> stealing | <input type="checkbox"/> hostile/angry | <input type="checkbox"/> extreme worrier | <input type="checkbox"/> frequently daydreamed |
| <input type="checkbox"/> often sad | <input type="checkbox"/> impulsive | <input type="checkbox"/> self-injurious acts | |
| <input type="checkbox"/> violent temper | <input type="checkbox"/> indecisive | <input type="checkbox"/> fire-setting | |

Intellectual/academic functioning (check all that apply to child):

- | | | |
|--|---|--|
| <input type="checkbox"/> normal intelligence | <input type="checkbox"/> mild retardation | <input type="checkbox"/> authority conflicts |
| <input type="checkbox"/> high intelligence | <input type="checkbox"/> moderate retardation | <input type="checkbox"/> attention problems |
| <input type="checkbox"/> special education from ____ to ____ for _____ | | |

Current or highest education level: _____

SOCIO-ECONOMIC HISTORY (check all that apply)

Living situation:

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous/deteriorating

Employment:

- employed and satisfied
- employed but dissatisfied
- unemployed
- coworker conflicts
- change jobs a lot
- disabled: _____

Financial situation:

- no current financial problems
- large indebtedness
- poverty
- impulsive spending
- relationship conflicts over finances

Social support system:

- supportive network
- few friends
- substance-use-based friends
- no friends
- distant from family of origin
- living companions dysfunctional

Legal history

- no legal problems
- now on parole/probation
- arrest(s) not substance-related
- arrest(s) substance-related
- court ordered this treatment
- jail/prison ___ time(s); total time served: _____
- describe last legal difficulty: _____

Sexual history:

- heterosexual orientation
- homosexual orientation
- bisexual orientation
- currently sexually active
- not currently sexually active
- currently sexually dissatisfied
- history of unsafe sex: ages ___ to ___
- age first sexual experience: ___
- age first pregnancy or fatherhood: ___
- history of promiscuity: ages ___ to ___

Cultural/Spiritual/Recreational history:

Cultural identity (e.g. ethnicity, religion): _____
 Describe any cultural issues that contribute to current problem: _____

	Yes	No
Active in community/recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>
Was active in community/recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>
Currently engage in hobbies?	<input type="checkbox"/>	<input type="checkbox"/>
Currently participate in spiritual activities	<input type="checkbox"/>	<input type="checkbox"/>

If answered "yes" to any of the above, describe: _____

 Name and city of church attended: _____

Describe any other developmental problems or issues: _____

MEDICAL AND PSYCHOLOGICAL HISTORY

Primary Care Physician: _____ Phone: _____

Psychiatrist (if any): _____ Phone: _____

Describe current physical health: Good Fair Poor

List any current medical conditions: _____

List any known allergies: _____

Describe any serious hospitalization or accidents. Include Date, Age, and Reason

Has child previously taken medication to treat psychological problems? no yes (include below)

List any medications currently taken:

Medication	Reason	Dosage	Freq	Start/End Date	Physician	Side Effects	Beneficial?
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Which of the following areas of functioning have been impaired by psychological problems? (Check all that apply)
 Occupational Academic Social Affective (Emotional) Physical

Is there a history of any of the following in the family?

- | | | |
|---|--|--|
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> mental retardation | <input type="checkbox"/> Alzheimer's disease or dementia |
| <input type="checkbox"/> birth defects | <input type="checkbox"/> heart disease | <input type="checkbox"/> stroke |
| <input type="checkbox"/> emotional problems | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> other chronic or serious health problems: |
| <input type="checkbox"/> behavior problems | <input type="checkbox"/> alcoholism | _____ |
| <input type="checkbox"/> thyroid problems | <input type="checkbox"/> drug abuse | _____ |
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | |

Has any family member ever received a psychiatric diagnosis or psychological treatment (inpatient or outpatient)?

No Yes (describe below)

Has any family member ever taken medication for a psychological problem? No Yes (describe below)

SUBSTANCE USE HISTORY (check all that apply)

Family alcohol/drug abuse history:

- | | |
|---|---|
| <input type="checkbox"/> father | <input type="checkbox"/> sibling(s) |
| <input type="checkbox"/> mother | <input type="checkbox"/> spouse/significant other |
| <input type="checkbox"/> stepparent/live-in | <input type="checkbox"/> children |
| <input type="checkbox"/> uncle(s)/aunt(s) | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> grandparent(s) | _____ |

Substance use status:

- | | |
|---|--|
| <input type="checkbox"/> no history of abuse | <input type="checkbox"/> sustained full remission |
| <input type="checkbox"/> active abuse | <input type="checkbox"/> sustained partial remission |
| <input type="checkbox"/> early full remission | |

Issues related to substance abuse:

- | | | | |
|------------------------------------|-----------------------------------|--|---|
| <input type="checkbox"/> hangovers | <input type="checkbox"/> assaults | <input type="checkbox"/> suicidal impulse | <input type="checkbox"/> tolerance changes |
| <input type="checkbox"/> seizures | <input type="checkbox"/> binges | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> loss of control of amount used |
| <input type="checkbox"/> blackouts | <input type="checkbox"/> job loss | <input type="checkbox"/> withdrawal symptoms | <input type="checkbox"/> relationship conflicts |
| <input type="checkbox"/> overdose | <input type="checkbox"/> arrests | <input type="checkbox"/> medical conditions | |

Substances used:

	First use age:	Current use? (Yes/No)	Last use age:	Frequency	Amount
<input type="checkbox"/> Alcohol	_____	_____	_____	_____	_____
<input type="checkbox"/> amphetamines/speed	_____	_____	_____	_____	_____
<input type="checkbox"/> barbiturates/owners	_____	_____	_____	_____	_____
<input type="checkbox"/> caffeine	_____	_____	_____	_____	_____
<input type="checkbox"/> cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> crack cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> hallucinogens (e.g, LSD)	_____	_____	_____	_____	_____
<input type="checkbox"/> heroin	_____	_____	_____	_____	_____
<input type="checkbox"/> inhalants (e.g., glue, gas)	_____	_____	_____	_____	_____
<input type="checkbox"/> marijuana or hashish	_____	_____	_____	_____	_____
<input type="checkbox"/> nicotine/cigarettes	_____	_____	_____	_____	_____
<input type="checkbox"/> PCP	_____	_____	_____	_____	_____
<input type="checkbox"/> prescription: _____	_____	_____	_____	_____	_____
<input type="checkbox"/> other: _____	_____	_____	_____	_____	_____

PREVIOUS TREATMENT

PSYCHIATRIC HOSPITALIZATIONS AND TREATMENT (INCLUDING CD TREATMENT)

Prior outpatient psychotherapy or counseling? No Yes If yes, complete the following:

Age at time	Psychotherapist/Counselor (Agency, City)	Duration	Circumstances for treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is child currently seeing any of the above? No Yes If yes, please include name here: _____

Prior hospitalizations or inpatient treatment for psychological or CD issues? [] No [] Yes If yes, complete the following:

Age at time	Hospital/Treatment Center	Duration	Circumstances for treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREVIOUS DIAGNOSES

Has child ever been diagnosed with a psychiatric, substance abuse, learning, emotional, or behavioral disorder??

[] No [] Yes If yes, complete the following:

Diagnosis	Age	Diagnosis made by	Agree?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT SYMPTOM CHECKLIST (Rate the intensity of the symptoms present in the last two weeks)

None = This symptom is not present at this time **Mild** = This symptom is currently impacting my quality of life, but not significantly impairing my day-to-day functioning **Moderate** = This symptom is significantly impacting my quality of life and/or day-to-day functioning **Severe** = This symptom is profoundly impacting my quality of life and/or day-to-day functioning

Symptom	None	Mild	Moderate	Severe
Depressed mood				
Low energy				
Sleep disturbances				
Dissociation				
Hyperactivity				
Bingeing				
Decreased sex drive				
Unresolved guilt				
Irritability				
Nausea/acid indigestion				
Social anxiety				
Self-mutilation/cutting				
Impulsive actions/speech				
Nightmares				
Elevated mood				
Losing train of thought				
Mood swings				
Disorganized				
Anorexia				
Social isolation				
Grief				
Phobias				
Headaches				
Loneliness				
Problems at Home				

Symptom	None	Mild	Moderate	Severe
Increased or decreased appetite				
Unplanned weight gain				
Unplanned weight loss				
Paranoid thoughts				
Poor concentration/indecisive				
Purging/over-exercising				
Excessive worrying				
Low self-worth				
Anger management problems				
Tension				
Hallucinations				
Racing thoughts				
Restlessness				
Loss of interest in normal activity				
Decreased creativity/productivity				
Unresolved anger				
Easily distracted				
Memories of trauma				
Hopelessness				
Marital problems				
Panic attacks				
Suicidal thoughts				
Feel panicky/anxious				
Work problems				
Has attempted suicide in the past				

Briefly describe how the above symptoms impair the child's ability to function: _____

ENVIRONMENTAL STRESSORS *(check all that apply and are current or recent)*

- | | | |
|---|--|--|
| <input type="checkbox"/> Death of a family member | <input type="checkbox"/> Death or loss of a friend | <input type="checkbox"/> Inadequate housing |
| <input type="checkbox"/> Health problems in family | <input type="checkbox"/> Inadequate social support | <input type="checkbox"/> Unsafe neighborhood |
| <input type="checkbox"/> Disruption of family by separation | <input type="checkbox"/> Living alone | <input type="checkbox"/> Discord with neighbors or landlord |
| <input type="checkbox"/> Disruption of family by divorce | <input type="checkbox"/> Difficulty with acculturation | <input type="checkbox"/> Extreme poverty |
| <input type="checkbox"/> Disruption of family by estrangement | <input type="checkbox"/> Discrimination | <input type="checkbox"/> Inadequate finances |
| <input type="checkbox"/> Marriage stress | <input type="checkbox"/> Adjustment to life cycle transition | <input type="checkbox"/> Insufficient welfare support |
| <input type="checkbox"/> Removal from the home | <input type="checkbox"/> Illiteracy | <input type="checkbox"/> Inadequate healthcare |
| <input type="checkbox"/> Remarriage of parent | <input type="checkbox"/> Academic problems | <input type="checkbox"/> Inadequate health insurance |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Discord with teachers or classmates | <input type="checkbox"/> Recent arrest or incarceration |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Unemployment | <input type="checkbox"/> Involved in litigation |
| <input type="checkbox"/> Parental overprotection | <input type="checkbox"/> Threat of job loss | <input type="checkbox"/> Victim of a recent crime |
| <input type="checkbox"/> Neglect of a child | <input type="checkbox"/> Stressful work schedule | <input type="checkbox"/> Exposure to war, disasters, or other hostilities |
| <input type="checkbox"/> Inadequate discipline | <input type="checkbox"/> Job dissatisfaction | <input type="checkbox"/> Discord with counselor, social worker, physician or other caregiver |
| <input type="checkbox"/> Discord with siblings | <input type="checkbox"/> Job change | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Birth of a sibling | <input type="checkbox"/> Discord with boss or coworkers | |
| <input type="checkbox"/> Birth of a child | <input type="checkbox"/> Homelessness | |

PRESENTING PROBLEMS

Please state any reasons for seeking therapy. For each problem please include any additional relevant information including the length of time this has been a problem.

- 1. _____
- 2. _____
- 3. _____

Therapist use only