# CHILD AND ADOLESCENT INTAKE FORM

To be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand your child. It, as all communications with your therapist, will be kept confidential to the full extent of Florida law.

## BACKGROUND INFORMATION

Date _____

Child's Name _____ Date of Birth _____ Age _____

Child lives with (✓ one): both biological parents _____ mother _____ father _____

mother & stepfather _____ father & stepmother _____ other _____

If parents are divorced, describe custody arrangements: _____

_____

Child's Address/City/St/Zip _____

_____ Child's Home Phone _____

Emergency Contact Person (other than parent)_____ Phone Number _____

## INFORMATION ABOUT CHILD'S MOTHER

Mother's Name _____ Age _____ Race _____

Employer _____ Occupation _____ Hrs/wk _____

Employer's Address _____

Can you be contacted at work by phone? Yes No Work phone _____ ext _____

Church _____ Active? Yes No

Previous Counseling / Therapy? Yes No If yes, when? _____

With whom and for how long? _____

## INFORMATION ABOUT CHILD'S FATHER

Father's Name _____ Age _____ Race _____

Employer _____ Occupation _____ Hrs/wk _____

Employer's Address _____

Can you be contacted at work by phone? Yes No Work phone _____ ext _____

Church _____ Active? Yes No

Previous Counseling / Therapy? Yes No If yes, when? _____

With whom and for how long? _____

## FAMILY MEMBERS

List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime:

| Name | Relationship to Child | Age | Highest School Grade Completed | Occupation |
|---|---|---|---|---|
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**DESCRIBE THE PROBLEM** If possible, list questions for which answers are sought: _____

_____

_____

_____

Problem Areas: In the following list, place a check mark (✓) next to each item which identifies an area of concern to you. Place 2 check marks (✓✓) by those items which are most important. (You may add written comments after areas checked.)

| | | | |
|---|---|---|---|
| _____ | Anger / Temper | _____ | Sexual Concerns |
| _____ | Depression | _____ | Thoughts of Suicide |
| _____ | Education | _____ | Trouble making decisions |
| _____ | Family Problems | _____ | Unhappy most of the time |
| _____ | Fearfulness | _____ | Use of Alcohol |
| _____ | Marital Problems | _____ | Use of Drugs |
| _____ | Physical Problems | _____ | Work |
| _____ | Problems with Social Relationships | _____ | Worry |
| _____ | Problems with Children | _____ | Other (specify) _____ |
| _____ | Religious / Spiritual Concerns | | _____ |

## MEDICAL HISTORY

List child's sickness, operations, and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:

_____

Have there been any previous psychological, psychiatric, neurological, or EEG evaluations? Yes No

When did your child last have a physical examination? _____

Physician's Name _____ Phone _____

Physician's Address _____

## ACADEMIC / SCHOOL INFORMATION

School Name _____ Grade _____ Teacher _____

List previous schools attended with dates: _____

_____

_____

_____

Has child ever repeated a grade? Yes No If so, when? _____

How does your child get along at school? _____

_____

Describe difficulties in learning at school: _____

_____

Have other family members had learning difficulties? _____

_____

Describe what your child likes to do for fun, special interests, hobbies, etc. _____

_____

Describe your child's religious background (religious denomination, is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.) _____

_____

_____

I learned about LifeSong Counseling Center from: Name _____

Signature _____ Date _____