



Child/Adolescent Intake Form to be Completed by Parent

To be completed by parent or guardian requesting services for a minor child. This information will help your counselor understand your child. As with all communications with your therapist, it will be kept confidential to the full extent of Georgia law.

Today's Date: _____

Name of person filling out intake/relationship: _____

How did you hear about us? _____

Identifying/Contact Information

Child's Name: _____ Date of Birth: _____ Sex: _____

Child's Address: _____

Home phone: _____

Child lives with: Both biological parents _____ Mother _____ Father _____

Mother and stepfather _____ Father and stepmother _____

Other (please specify): _____

If parents are divorced, describe custody arrangements: _____

Information about child's mother

Mother's Name: _____ Date of Birth _____

Address: Same _____ If different: _____

Home phone _____ Cell: _____

Occupation: _____ Employer: _____

Work address: _____

Work phone _____ Can mother be contacted at work? Yes ___ No ___

Information about child's father

Father's name: _____ Date of Birth: _____

Address: Same: _____ If different: _____

Home phone: _____ Cell: _____

Occupation: _____ Employer: _____

Work address _____

Work phone _____ Can father be contacted at work? Yes ___ No ___

Other Family Members

Please list child's siblings, including any step siblings, in birth order and their ages. Indicate where child falls in birth order. Specify if sibling living with child now.

Child's Name	Age	Living in home now?

List other family members that live in household and their relationship to child:

Developmental History

Were there any complications surrounding the child's birth? Yes ____ No ____

If yes, please describe _____

Were developmental milestones normal? (walking, talking, toilet training) Yes ____ No ____

If no, then please describe _____

List child's sicknesses, operations, and injuries. Indicate age when occurred and describe severity. Pay special attention to head injuries and any time your child was unconscious, had convulsions, a high fever or hospitalization: _____

List current medical problems _____

Is child currently taking any prescription medications? Yes _____ No _____

If yes, please list:

Name of drug _____ Dosage _____ For what condition? _____ Who prescribed it? _____

When was your child's last physical exam? _____

Name of primary care physician _____

Academic/school Information

Name of School child attends _____

Grade _____ Teacher _____ County _____

Has child ever repeated a grade? _____ Which one? _____

What kind of grades does your child get? _____

Does child have any learning difficulties? If so, please specify _____

Describe your child's behavior at school _____

Describe your child's personality at school (example: shy, outgoing, friendly, active) _____

How easily does your child make friends? _____

How does your child's teacher describe your child? _____

What kinds of extracurricular activities does your child participate in? _____

Describe what your child likes to do for fun at home _____

Counseling Concerns

Describe briefly the problem which prompted you to seek counseling for your child at this time: _____

When did the problem appear? _____

Have there been times when the problem got better or disappeared? _____

What do you think helped? _____

Were there times when the problem has been especially bad? _____

Are there other people who play a major role in causing this problem, or in helping the child or you cope with the problem? _____

Is there anything else you would like your counselor to know at this time? _____

Scale of Current Concerns

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item. You may add written comments if you wish.

0	1	2	3	4	5	6	7	8	9	10
No concern			Moderate concern				Extreme concern			

- | | |
|--|-----------------------------------|
| _____ Anger/temper | _____ Talk of suicide |
| _____ Depression | _____ Unhappy most of the time |
| _____ Divorce/separation of parents | _____ Use of alcohol |
| _____ Adjustment to parent's remarriage | _____ Use of drugs |
| _____ School performance | _____ Work |
| _____ Family problems | _____ Worry |
| _____ Fearfulness | _____ Self-esteem |
| _____ Physical problems | _____ Poor appetite |
| _____ Problems with social relationships | _____ Overeating |
| _____ Problems sleeping | _____ Bedwetting |
| _____ Nightmares | _____ Soiling |
| _____ Sexual concerns | _____ Cruelty to animals |
| _____ Religious/spiritual concerns | _____ Fire setting |
| _____ Behavioral acting out | _____ Excessive crying or whining |

Other problems: _____

Has your child had any previous counseling? If yes, where and by whom? _____