Child and Adolescent Intake

To be filled out by parent or guardian, then added to by clinician.

Name: _______________________________ DOB: _____________ Date: ______

Please answer these questions so that the child's problem list and treatment plan are correct.
This information is private. It cannot be released without your permission.
Explain all "YES" answers on the lines provided near or below each section.

Reason for this evaluation:

1. Why do you think this child may need mental health services? What kinds of problems have been going on? ____
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2. When did these problems get started? ___ days, weeks, months, years ago (circle one).
3. How long do you think it will take to take care of them? ____________________________
4. Has the child ever had any treatment for depression, addiction, or emotional problems? ☐ Yes ☐ No
   Where? With Whom? ____
   Medication? ☐ yes ☐ no What kind?
____
Was hospitalization needed? ☐ yes ☐ no Where? How many times?

Question #

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Reviewed by: __________________________________ Date: __________

Early Life and Development

5. Was the child's BIRTH out of the ordinary? ☐ yes ☐ no
6. During the FIRST SIX MONTHS of life, were there problems with growth or function? ☐ yes ☐ no
7. Were there any delays or problems with (circle all that apply) sleeping, eating, weaning
   growing, crawling, talking, or speaking, toilet training, playing, coordination? ☐ yes ☐ no
8. Did the child have a difficult TEMPERAMENT ? ☐ yes ☐ no
   poorly ACCEPTED by the family? ☐ yes ☐ no
   DESCRIBE THE CHILD: ☐ leader ☐ joiner ☐ shy ☐ fearful ☐ aggressive ☐ fearless
9. Has the child had any serious MEDICAL PROBLEMS?
   ☐ Between birth and age 3? ☐ Between 3 and 5 years of age? ☐ Between 5 and 18 years
10. Any DIFFICULTIES (circle all that apply) being AWAY from home, refused to go to SCHOOL,
    trouble GETTING ALONG with kids, teachers, or other adults? ☐ yes ☐ no
11. Serious loss, abuse, separations, witness abuse or other PAINFUL EXPERIENCES? ☐ yes ☐ no
12. How does the child get PUNISHED? (check all that apply) ☐ spanking ☐ time out ☐ grounded
    ☐ points ☐ natural consequences ☐ other ______________________________
13. Do you ever feel that you (or parents) are losing CONTROL? ☐ yes ☐ no

Explain "yes" answers below. Use the back of the sheet if needed.

Question #

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Day-to day Life

14. What SCHOOL? ______________________________ Grade ___________ Teacher_____________
    Average GRADES(S) ______ Any special classes (Resource room, SED, LD, EH, etc.)_____________
15. RELIGIOUS affiliation: ___________________________________ Regular attendance ☐ yes ☐ no
16. Any LEGAL PROBLEMS (circle all that apply) arrests, probation, shoplifting, curfew, sexual, trouble with the police, juvenile authorities, fires, drugs or alcohol?
17. What may be causing STRESS? (illness, school, loss, family fights, divorce, brother, sisters, etc.)

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    How well do you think the child is COPING? ☐ Poorly ☐ well enough ☐ could be better ☐ Very well
18. What are his strengths and interests? ____

____

____

19. What does he/she do for fun?(sports, hobbies, community or church acitivities, TV, friends, etc.)?

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FAMILY

20. Did the child go through a DIVORCE or separation? ☐ Yes ☐ No Was it difficult? ☐ yes ☐ no
    Is support sufficient? ☐ yes ☐ no Payor: ____
    Custody: __________________________(physical) ______________________________ (legal)
    Visitation: ____
    Are there conflicts with these arrangements? ☐ yes ☐ no
    Was the child brought up by people other than the birth parents? ☐ yes ☐ no
21. Have any BLOOD RELATIVES have emotional or addictive problems? ☐ yes ☐ no
22. Please list below everyone who is living in the home or "step-home".

Name	Age	Relationship	
______________________	_____	_________________	☐ Home ☐ Step-home ☐ Neither
______________________	_____	_________________	☐ Home ☐ Step-home ☐ Neither
______________________	_____	_________________	☐ Home ☐ Step-home ☐ Neither
______________________	_____	_________________	☐ Home ☐ Step-home ☐ Neither
______________________	_____	_________________	☐ Home ☐ Step-home ☐

Question#

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Health

23. Any current or past MEDICAL PROBLEMS (circle the ones that apply)

asthma or other breathing problems	frequent coughing	coughing blood	fever
arm, leg, or other joint pain	motion sickness	stomach aches	nausea
jaundice or other liver problems	vomiting	bloody stools	diarrhea
unusual weight gain or loss	constipation	rash	allergies
unusual or early sexual behavior	anemia	diabetes	thyroid
kidney problems	heart problems	murmur	leg swelling
problems sleeping	bed wetting	back problems	drug problems
headaches	seizures	convulsions	epilepsy
black-outs	head injury		

Other: ____

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____

24. Have any BLOOD relatives had HEART PROBLEMS or died from unknown causes? ☐ yes ☐ no
25. Has the child had an EKG (heart monitor)? ☐ yes ☐ no Was it abnormal? ☐ yes ☐ no
26. Had a head injury, an EEG (brain wave test) or seen a neurologist (brain specialist)? ☐ yes ☐ no
27. Any ALLERGIES to medications? ☐ yes ☐ no

    Which one(s)?____
28. Is he/she currently taking any MEDICATIONS or receiving any TREATMENTS? ☐ yes ☐ no

name and amount	**times/day**	**purpose**	**DOCTOR**
____________________	______	______________	______________
____________________	______	______________	______________
____________________	______	______________	______________
____________________	______	______________	______________
____________________	______	______________	______________
____________________	______	______________	______________

Explanation____

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29. Is the child's diet poor? ☐ yes In what way? ______________________________ ☐ no
30. How many CAFFEINATED beverages (e.g., colas, tea, coffee) does he/she drink each day?
31. For teenage girls ONLY: ☐ having monthly periods? ☐ pregnant? ☐ using birth control?

    Explain yes answers below. Use the back of this sheet if needed.

Question#

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