# *LIVING IN AUTHORITY COUNSELING SERVICES*

## Child/Adolescent Intake Form

Name: _____ Date: _____

### PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____
_____

Please check all your child's behaviors and symptoms that you consider problematic:

| | | | |
|---|---|---|---|
| ☐ Distractibility | ☐ Change in appetite | ☐ Visual hallucinations | ☐ Manipulative behavior |
| ☐ Hyperactivity | ☐ Withdrawal from people | ☐ Defiance | ☐ No/few friends |
| ☐ Impulsivity | ☐ Anxiety/worry | ☐ Aggression/fights | ☐ Eating problems |
| ☐ Boredom | ☐ Panic attacks | ☐ Homicidal thoughts | ☐ Sleep problems |
| ☐ Poor memory/confusion | ☐ Fear away from home | ☐ Frequent arguments | ☐ Nightmares |
| ☐ Sadness/depression | ☐ Social discomfort | ☐ Irritability/anger | ☐ Toileting problems |
| ☐ Hopelessness | ☐ Phobias | ☐ Peer/sibling conflict | ☐ Fire setting |
| ☐ Thoughts of death | ☐ Obsessive thoughts | ☐ Stealing | ☐ Work/school problems |
| ☐ Self-harm behaviors | ☐ Compulsive behavior | ☐ Destroys property | ☐ Legal problems |
| ☐ Crying spells | ☐ Racing thoughts | ☐ Running away | ☐ Sexual behavior |
| ☐ Loneliness | ☐ Wide mood swings | ☐ Swearing | ☐ Computer addiction |
| ☐ Low self worth | ☐ Suspicion/paranoia | ☐ Curfew violations | ☐ Alcohol/drug use |
| ☐ Fatigue | ☐ Hearing voices | ☐ Lying | ☐ Lack of motivation |
| ☐ Recurring, disturbing memories | | ☐ Other:_____ | |

Are your child's problems affecting any of the following?

| | | | | |
|---|---|---|---|---|
| ☐ Handling everyday tasks | ☐ Self esteem | ☐ Relationships | ☐ Hygiene | ☐ Health |
| ☐ Recreational activities | ☐ Work/School | ☐ Housing | ☐ Legal matters | ☐ Finances |

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt him/herself? If yes, please describe: _____
_____

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____
_____

☐ Yes ☐ No Has your child recently been physically hurt or threatened by someone else? If yes, please describe: _____
_____

☐ Yes ☐ No Has your child gambled in the past 6 months? If yes, let us know the following
☐ Yes ☐ No Has your child ever felt the need to bet more and more money?
☐ Yes ☐ No Has your child ever had to lie to people about how much your child has gambled?

| Therapist Notes: |
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| Init: ____ |

Name: _____

## FAMILY AND DEVELOPMENTAL HISTORY

| Relationship | Name | Lives with Child? | Age | Quality of Relationship |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Stepmother | | | | |
| Stepfather | | | | |
| Siblings | | | | |
| | | | | |
| | | | | |
| | | | | |
| Other relatives | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Family Mental Health Problems | Who? |
|---|---|
| Hyperactivity | |
| Sexually Abused | |
| Depression | |
| Manic Depression | |
| Suicide | |
| Anxiety | |
| Panic Attacks | |
| Obsessive-Compulsive | |
| Anger/Abusive | |
| Schizophrenia | |
| Eating Disorder | |
| Alcohol Abuse | |
| Drug Abuse | |

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times _____
☐ Father remarried: Number of times _____

Please check if your child has experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

☐ Yes ☐ No Were there any medical problems during the pregnancy or birth of your child? If yes, please describe: _____

☐ Yes ☐ No Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? If yes, please describes substances used, quantity, and frequency: _____
_____

☐ Yes ☐ No Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? If yes, please describe: _____
_____

| Therapist Notes: |
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| Init: ____ |

Name: _____

## PREVIOUS MENTAL HEALTH TREATMENT

| Yes | No | Type of Treatment | When? | Provider/Program | Reason for Treatment |
|---|---|---|---|---|---|
| | | Outpatient Counseling | | | |
| | | Medication (mental health) | | | |
| | | Psychiatric Hospitalization | | | |
| | | Drug/Alcohol Treatment | | | |
| | | Self-help/Support Groups | | | |

| Therapist Notes: |
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| Init: ____ |

## SCHOOL INFORMATION

Current grade/placement: _____

| | | | | |
|---|---|---|---|---|
| This year's school grades: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| Past school grades: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| This year's school behavior: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| Past school behavior: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |

Has your child had any of the following difficulties at school?

| | | | |
|---|---|---|---|
| ☐ Suspension | ☐ Incomplete homework | ☐ Learning problems | ☐ Referrals or detentions |
| ☐ Poor grades | ☐ Teased or picked on | ☐ Speech problems | ☐ Attendance problems |
| ☐ Gang influence | | | |

☐ Yes ☐ No Does your child have an after-school provider? If so, who? _____

☐ Yes ☐ No Has your child ever repeated or skipped a grade? If yes, which one(s)?_____

☐ Yes ☐ No Has your child ever received Special Education services? If yes, please describe services received and reason for services: _____

What does your child's teacher(s) say about him/her? _____

| Therapist Notes: |
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Name: _____

## SUBSTANCE USE HISTORY (for ages 12 and older or if applicable)

| Substance Type | Current Use (last 6 months) | | | | Past Use | | | |
|---|---|---|---|---|---|---|---|---|
| | Y | N | Frequency | Amount | Y | N | Frequency | Amount |
| Tobacco | | | | | | | | |
| Caffeine | | | | | | | | |
| Alcohol | | | | | | | | |
| Marijuana | | | | | | | | |
| Cocaine/crack | | | | | | | | |
| Ecstasy | | | | | | | | |
| Heroin | | | | | | | | |
| Inhalants | | | | | | | | |
| Methamphetamines | | | | | | | | |
| Pain Killers | | | | | | | | |
| PCP/LSD | | | | | | | | |
| Steroids | | | | | | | | |
| Tranquilizers | | | | | | | | |

☐ Yes ☐ No Has your child had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

☐ Yes ☐ No Has your child ever had problems with work, relationships, health, the law, etc. due to his/her substance use? If yes, please describe: _____

| Therapist Notes: |
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| Init: ____ |

## MEDICAL INFORMATION

Date of last physical exam: _____

Has your child experienced any of the following medical conditions during his/her lifetime?

☐ Allergies ☐ Asthma ☐ Headaches ☐ Stomach aches
☐ Chronic pain ☐ Surgery ☐ Serious accident ☐ Head injury
☐ Dizziness/fainting ☐ Meningitis ☐ Seizures ☐ Vision problems
☐ High fevers ☐ Diabetes ☐ Hearing problems ☐ Ear infections
☐ Miscarriage ☐ Abortion ☐ Sleep disorder ☐ Sexually transmitted disease
☐ Other: _____

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

| Medication | Dosage | Date First Prescribed | Prescribed By |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____
_____

Allergies and/or adverse reactions to medications: ☐ None
If yes, please list: _____

| Therapist Notes: |
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## INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your child's social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one? _____)

To which cultural or ethnic group does your child belong? _____
If your child is experiencing any difficulties due to cultural or ethnic issues, please describe:_____
_____

How important are spiritual matters to your child? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much
☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your child's counseling?

Please describe your child's strengths, skills, and talents? _____
_____
Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____
_____

| Therapist Notes: |
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| Init: ____ |

## LEGAL INFORMATION

If the parents are separated or divorced, what is the current child custody/visitation arrangement? _____
_____

☐ Yes ☐ No Is your child currently the subject of a custody case?
☐ Yes ☐ No Has your child ever been a ward of the court with SCF/DCFS guardianship?
☐ Yes ☐ No Does your child have any legal offenses on record or pending in the courts?

| Therapist Notes: |
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| Init: ____ |