SAINT LOUIS COUNSELING

Intake Forms – Child and Adolescent

PRESENTING PROBLEM

Please tell us why you are seeking services for your child at this time._____

_____

_____

What do you hope to accomplish from the services received?_____

_____

SYMPTOM CHECKLIST – Please check all that apply.

Past	Present		Past	Present	
		Addictions			Hopelessness
		Aggressive behavior			Hyperactivity
		Anger			Impulsivity
		Anxiety/worry			Isolation
		Appetite changes			Lack of motivation
		Breaking the law			Learning problems
		Crying spells			Loss/death of a significant person
		Decreased energy			Marital/relationship problems
		Depression			Mood swings
		Developmental disabilities			Physical complaints
		Difficulty concentrating			School problems
		Disobedience			Self-mutilation
		Drugs/alcohol			Sexual problems
		Eating disorders			Sleep changes
		Fears			Speech/language problems
		Fighting			Stress
		Fire setting			Suicidal thoughts
		Hallucinations			Temper tantrums
		Health problems			Wets bed
		Homicidal thoughts			Other:

FAMILY AND SOCIAL INFORMATION

Please list family members and other individuals who live at the child's address.

Name	Relationship	Age	Marital Status

Please list other family members who do not live at the child's address, including half, step, and foster family members.

Name	Relationship	Age	Marital Status

Who has legal custody of the child?_____

If the child's biological parents are not living, please indicate date and cause of death._____

_____

If the child is adopted, please provide any known information about the biological parents, including contact with child.

_____

Has the child or any family member been physically, emotionally, or sexually abused? If yes, please describe.

_____

Has the child ever been a perpetrator of abuse? If yes, please describe._____

_____

Has the child been exposed to any stressful or traumatic situations such as witnessing violence, death of a significant person, family problems, etc.? If yes, please describe._____

_____

Is spirituality/religion a part of the child's life? If yes, please describe._____

_____

Who are the child's main social supports?_____

_____

How does the child get along with other children?_____

EDUCATION INFORMATION

Please list all schools attended, beginning with the most current.

Name of School	Grades	Reason for Leaving

What are the child's usual grades in school?_____

Has the child ever failed or advanced a grade? If yes, please describe._____

Has the child ever been diagnosed with a learning or conduct disorder? If yes, please describe._____

_____

Has the child ever been bullied in school? If yes, please describe._____

What is the child's view of school?_____

EMPLOYMENT INFORMATION

If the child works, please indicate place, position, and hours._____

LEGAL INFORMATION

Has the child ever been arrested? If yes, please describe._____

_____

Is the child currently on probation or parole? If yes, please describe._____

_____

Is the child currently involved in any legal actions, such a child custody case? If yes, please describe._____

_____

Has the child ever received a DWI or DUI? If yes, please describe_____

SUBSTANCE ABUSE INFORMATION

Does the child smoke or use tobacco? If yes, how much and how often?_____

Does the child or any family member currently use or have a history of alcohol/drug abuse/dependency? If yes, please describe.

_____

MEDICAL INFORMATION

Please answer the following questions regarding the child's development.

	Yes	No	NA
The pregnancy was drug and alcohol free.			
Child sat alone between six and nine months?			
Child crawled between seven and twelve months?			
Child walked alone between nine and fifteen months?			
Child talked between twelve and thirty months?			
Child was toilet trained between two and three years?			

Pediatrician_____ Phone #_____ Last Exam Date_____

Please list any current and past impairments, illnesses, surgeries, and hospitalizations._____

_____

Allergies_____

How often does the child exercise?_____

Current Medications

Name of Medication	Dosage	Frequency	Taken As Prescribed?	Date Started	Prescribing Physician	List Any Side-Effects

Please list any current and previous counseling and psychiatric treatment for you and/or any family members.

Individual Receiving Treatment	Type of Treatment (i.e., outpatient, inpatient, residential, chemical dependency, etc.)	Service Provider	Dates

STRENGTHS

Please list some of the child's strengths and positive qualities._____

_____

What hobbies, interests, and extracurricular activities does the child enjoy?_____

_____

Is there anything else you would like us to know?_____

_____