Child/Adolescent Intake

Child Name: ____ DOB: ________________________

Address: ____City ____________ Zip _____________________

Sex ☐ Male ☐ Female Age: _________

School attending ____ Grade (current or entering) ___________

Is patient adopted? Yes No If yes, at what age? _____________________

Race/Ethnicity

☐ Caucasian ☐ Native American ☐ Multiracial ________________________________

☐ African American ☐ Asia ☐ Latin or Spanish ☐ Other _________________

Biological Parents (or Guardian information):

Are Biological parents divorced or separated? Yes No If yes, for how long ____________________________

If yes, do parents share custody? Yes No** ** **Court documentation must be provided

Parent: ____ Relationship _________________________

Phone: ___________________________________ okay to leave msg? ☐ Yes ☐ No

Occupation: ____

Email: ____ okay to use email? ☐ Yes ☐ No

Co-Parent:____ Relationship _________________________

Phone: ___________________________________ okay to leave msg? ☐ Yes ☐ No

Occupation: ____

Email: ____ okay to use email? ☐ Yes ☐ No

Siblings (include biological, adopted, foster, step, etc.)

Name	Sex	Age	Type (bio,step,etc.)	Custody?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Anyone else living in your household other than parents or siblings? Yes No

***If yes, please give name(s) and relationship:

____

Person to contact in case of emergency Phone Number

COUNSELING HISTORY OF CHILD/ADOLESCENT

Prior counseling experience:

From: _________________ To: ____________________ With Whom? ____________________________

How were you referred to me? ____

Is there any history of mental health issues in family? (if yes, please describe) ________________________
____

Basic Health ☐ Good ☐ Fair ☐ Poor Date of last exam? ____________________________
Physician's Name: ________________________________ Phone: _________________________________

Is child/adolescent taking any prescription medication at this time? ☐ Yes ☐ No

If yes, what? ____

Is child/adolescent taking any over the counter medication at this time? ☐ Yes ☐ No

If yes, what? ____

Current reason for seeking counseling

Are there any physical, emotional, or mental issues now or in the past that I need to be aware of ? Yes / No

If yes, what? ____

Has child/adolescent ever been hospitalized? Yes / No

If yes, for what and when ____

Briefly describe the problem for which you wish your child/adolescent to have counseling:

____

____

____

The thing that concerns me most right now is: ___________________________________

____

____

____

Counseling would be successful if: ____

____

I understand that suicidal threats, homicidal threats or child abuse will be reported.
I understand that the parent must facilitate the ability for child/adolescent to trust the therapist and will respect confidentiality when appropriate.

Parent (s) Signature : ____________________________________ ________________________________

Print names : ____________________________________ ________________________________

Adolescent Signature: ____

Initial Service Plan

Please check any of the reasons listed below which resulted in your coming in today:

- ☐ Depression or Anxiety
- ☐ Alcohol or other drug abuse
- ☐ Communication Difficulties
- ☐ Harm to self or others
- ☐ Abuse (physical/verbal/sexual)
- ☐ Sexual Orientation Questions
- ☐ Child Adjustment/Parent Conflict
- ☐ Divorce
- ☐ Adoption
- ☐ ______________________________
- ☐ Difficulty with loss or death
- ☐ School adjustment problems
- ☐ School learning difficulties
- ☐ Low Self Esteem/social withdraw/motivation
- ☐ General Defiance
- ☐ Staying Focused/Task Completion
- ☐ Eating Disorder/Obesity
- ☐ Individual Counseling
- ☐ Family Counseling
- ☐ ________________________________

What event happened which made you think "I am (we are) calling a therapist?" ____________________________
____
____

Modality – who would you like to see participate in counseling?:
____
____
____

What behaviors would you like to change? ____
____
____

Patient's strengths and interests: ____
____
____

Specific Goals identified (can be completed with therapist) Plan Review Date: 6 months from intake
____
____
____

Patient Signature ____ Date ______________________________

Parent Signature____ Date ______________________________

Signature____ Date ______________________________
Yami Martinez-Lewis, MPH, M.S., LAMFT 6660T

Supervisor Signature____ Date ______________________________
Dr. Nancy Frigaard, D.Min., LMFT 15231