5618 White Bluff Rd Suite B & C
Savannah Ga, 31405 Main Office

131 Silverwood Ct.
Rincon, GA. 31326 Secondary location

Child / Adolescent Intake Document

Basic Information

Client's Name _____
Date of Birth _____
Today's Date _____

Parent's Name _____
_____

Full Address _____

_____

Home Phone _____ Cell Phone_____

E-mail _____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

□ Medical Provider: _____

□ Insurance Provider: _____

□ Website at http://www

□ Psychology Today website

□ Friend/Family:

_____

Have you previously received any type of mental health services? □ No □ Yes

If yes, which of the following:

□ psychotherapy □ medication □ outpatient hospitalizations □ inpatient hospitalization

Please provide:

Name of provider or facility: _____

Location: _____

Dates of treatment: _____

Reason for treatment: _____

Briefly, what brings you in today ?

When did your problem first start? Within the last:

□ 30 days □ 6-12 months □ 2 years

Physical History

What is the name of your child's medical doctor? _____

Address: _____
Phone: _____

Date of your child's last medical examination & describe:

_____

Did your child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Is your child currently taking any medication? _____
If yes, what kind? _____

Reason for medication_____
For how long? _____

Has your child ever been hospitalized for a physical illness? ____

Describe_____

_____

_____

Has your child ever been hospitalized for a mental illness? ____

Describe_____

_____
_____

Any recent major surgeries? _____

Any recurrent or chronic conditions? _____

Does your child smoke? _____ Does your child take drugs? _____
If yes, what kind? _____

Does your child drink? _____ How much? _____

Any Previous Psychological testing? _____
If yes, describe, results

_____

_____

_____

Note: If your child has been previously evaluated, please provide a copy of the report.

Developmental History

Were there any problems or complications during the pregnancy or at delivery? If so, please describe them:

Did your child have any delays in reaching developmental milestones? Please estimate when your child gained these skills.

Talking? Walking?

Potty Training? Sitting? Crawling?

Has your child experienced any of the following medical problems in the past?

A serious accident Hospitalization Surgery

Asthma A head injury High fever

Convulsions/Seizures Allergies Eye/ear problems

Meningitis Hearing problems Loss of consciousness

Other

Family History:

The name of the child's biological parents:

Mother:_____
Father:_____

Who has legal guardianship of your child?

Any current Legal issues?

Who does your child currently live with?

Names	**Ages**	**Relationship to child**

Who are significant people in your child's life that do NOT life with him/her?

Names	**Ages**	**Relationship to child**

Has anyone in your family ever been diagnosed with a mental health disorder or has experienced mental health challenges? If yes, what relation are they to your child and what was there identified mental health diagnosis?

History of Trauma or Abuse:

Any Major Life Transitions (Death, Separation, Moving to a new place, Divorce, Chronic Illness, New school) :

Education History:

What school does your child attend?

Address:_____

_____

Phone:_____ Teachers
Name:_____

Current Grade:_____

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

Other schools attended (including Pre-school)

Has your child ever repeated a grade? If so which one(s)

Has your child ever received special education services?

If yes, please provide a copy of your child's most recent IEP or 504 Plan

Psychological History

Has your child ever had difficulty with the following: (If so, please specify when)
Depressed mood, feelings of helplessness or worthlessness, and decreased motivation

Stress, anxiety, or tension that was beyond what would be expected for a given event

Distressing physical sensations such as shortness of breath, racing heart, dizziness, etc.

Obsessive thoughts or images that s/he could not ignore

Repetitive behaviors or rituals that s/he felt compelled to complete

Distressing memories, flashbacks, or dreams in response to a traumatic event including nightmares

Over the last two weeks, how often have you noticed your child may have been bothered by any of the following problems?

	Not at all	Several days	More than ½ the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down or hopeless or sad				
Feeling tired or having little energy				
Poor appetite or overeating				
Difficulty concentrating				
Feeling irritable				
Poor sleeping or excessive sleeping				

If you checked off any problems, how difficult were these problems regarding your child's ability to complete daily tasks like schoolwork, chores, and getting along with others?

Not at all difficult Somewhat difficult Very difficult Extremely difficult

Has there ever been a time when your child was not his/her normal self and…

	Yes	No
They were so hyper they didn't appear themselves?		
They felt so good it led to getting in trouble?		
They slept less than usual but didn't seem to need it?		
They had more energy and completed more activities than usual?		

They were much more irritable than usual?		
They were much more social than usual? For example, calling friends in the middle of the night; chatting with strangers		
They engaged in risky behavior?		
They showed hypersexual behavior?		

If you checked yes to more than one of the above, have several of these ever happened during the same period of time? (If so, please mark which ones above)

How much of a problem did any of these cause your child – like being unable to attend school; having family, money, or legal troubles; getting into arguments or fights?

No problem Minor problem Moderate problem Serious problem

Have any of your blood relatives been diagnosed with bipolar disorder? _____

Please answer the questions below using the option on the right that best describes what you may have noticed in your child over the past six months.

	Never	Rarely	Sometimes	Often	Always
How often does s/he have difficulty staying organized?					
How often does s/he have problems remembering things?					
How often does s/he fidget or squirm when required to stay seated?					

How often does s/he make careless mistakes?					
How often does s/he have difficulty paying attention during boring or repetitive tasks?					
How often does s/he misplace items?					
How often is s/he distracted?					
How often does s/he interrupt others who are talking?					
How often does s/he have trouble unwinding after an activity or day?					
How often does s/he have trouble waiting his/her turn?					
How often does s/he appear to "space out"?					

Cultural/ Spiritual Information:

How will you identify yourself or Your child ethnically?

Describe your/ Your child's spiritual beliefs?

What do you hope to gain through counseling?

What goals do you have for your child as s/he grows into an adult?

What are areas of strengths for your child?

What are your child hobbies, Interests and extracurricular activities?

Do you have any other worries or concerns about moving forward with assessment / treatment? If yes, please describe

I understand that it is important to provide accurate information in order to tailor treatment and assessment to meet my child's needs. This information is correct as I have described it.

_____ _____

Parent/Guardian Signature Date