Child / Adolescent Client Intake Information

The purpose of the following questionnaire is to help your counselor understand some important things about your child in order to help your child and your family most effectively. Please complete all pages.

Child's Full Name: _____ Date: _____

Child's date of birth: _____ Age: _____ Sex: Race:

Address: _____

Telephone numbers: Home: _____ Cell: Work: _____

Is it okay to leave a message at home/ cell/ on work phone: _____

E-mail Address: _____

Caregiver/Parent Name(s):

Caregiver/Parent(s) date of birth: _____

Emergency Contact: Name: _____ Phone Number: _____

Marital Status:

Single_____	Divorced_____	Engaged_____
Separated_____	Widowed_____	Other_____
Married_____	No. of Years_____	Name of Spouse_____

Spouse's Age_____ Spouse currently living with you?_____

Previous Marriages (Nos. and length of each)_____

Custody Status: _____

How did you hear about Still Waters Ministries? _____

Presenting Problem:

Please circle stressors you have had in recent months:

Marital Issues Health Issues Job Issues Financial Issues Parent/Child Issues

Issues in Past Other: _____

Child's Presenting Problem(s): (please circle all that apply)

Sexual abuse	Physical abuse	Neglect	Delinquent behavior	Nightmares
Suicidal thoughts	Sexually acting out	Sleeping problems	Anxiety	Shyness
Academic problems	Change in appetite	Concentration	Bed wetting	Stealing
Clinging behavior	Impulsivity	Temper outbursts	Withdrawn	Lying
Peer conflict	Drug use	Alcohol use	Stubborn	Running away
Missing school	Health issues	Strange thoughts	Legal trouble	Harming self
Head banging	Overactive	Skipping school	Sexual problems	Fearful

Other problems and/or concerns: _____

How long have these problems occurred (number of weeks, months, years): _____

Child/Adolescent Client Intake (continued)

Why did you decide to seek counseling at this time? _____

_____

Child/Adolescent Client Intake (continued)

Describe how you hope counseling will help your child: _____

_____

_____

Describe how you hope counseling will help you and your family: _____

_____

_____

Psychosocial History:

Current Family Situation:
List the occupants in the home, even if temporary: _____

_____

Biological siblings (list names and ages in order of oldest to youngest): _____

_____

Are there any current concerns regarding siblings (please list concerns)? _____

_____

_____

Has the child ever been exposed to domestic violence? _____

Traumas or losses (please indicate the loss or trauma and the age of the child) _____

_____

_____

Living Arrangements:

Is there currently a custody dispute? ____yes ____no _____possibly

Is there weekend visitation with a non-custodial parent? _____yes _____no

Has your child recently moved? ____yes _____ no Number of moves in child's life: _____

Who makes the decisions regarding the household money, discipline, routine:

What is your major form of discipline? (example: grounding, spanking, taking away TV, etc.)

Who is the major disciplinarian? _____

Physical / Mental Health of Client and Family Members

Please note all health problems your child has had or has now:

High fever _____	Dental problems _____	Dizziness ____	Sinus problems_____
Pneumonia _____	Weight problems _____	Tonsils out ____	Heart problems _____
Flu _____	Allergies _____	Vision problems ____	Hyperactivity _____
Encephalitis _____	Skin problems _____	Hearing problems ____	High/Low
Meningitis ____	Asthma _____	Earaches ____	Blood pressure _____
Convulsions ____	Headaches _____	Fainting ____	
Unconsciousness ____	Stomach problems _____	Convulsions ____	Accident prone _____
Head injury ____	Anemia _____		

Major illness or physical limitations? _____

Has your child ever been hospitalized? If so please explain: _____

_____

Please list all medications your child is taking: _____

_____

Name of primary care physician: _____

Name of other physicians your child is seeing, especially psychiatrists: _____

_____

Has your child ever seen a therapist before? ____yes _____no Name of therapist: _____

What was the presenting problem? _____

Duration of therapy: _____

Has your child ever had a psychiatric diagnosis? _____

Family Medical and Psychiatric History:

Medical problems or disabilities in the family: _____

_____

Psychiatric history in family: _____

Substance abuse history: _____

Developmental History

Prenatal:

Please list any problems or complications with pregnancy or delivery: _____

Developmental Milestones:
(Referring to age when the child walked, talked, potty trained, etc.)

Additional Comments: _____

_____

_____

_____

Educational History:

Name of child's school: Grade: _____

Teacher(s) name:_____ Average grades: _____

Concerns regarding school academics or behavior: _____

Have there been any significant changes or problems in school behavior or grades? _____

_____

_____

Child's best subject: _____ Child's most challenging subject: _____

Please check the following according to your child:

Learning disabilities? _____yes _____no If yes, please explain? _____

_____

_____

Gifted program? _____yes _____no

ADHD? _____yes _____no

Participate in extracurricular activities? _____yes _____no (explain) _____

_____

_____

Social history:

In school how many friends does your child have: _____a lot _____a few _____none

How much time does your child spend with other children outside of school during the week?

0-1 day_____ 2-3 days_____ 4-5 days_____ more than 5 days_____

Child/Adolescent Client Intake (continued)

Please list child's special interests, hobbies, skills: _____

_____

Who does your child spend most of his/her time with? _____

_____

How does your child get along with:

Peers? _____

Adults? _____

Teachers? _____

Parents? _____

Other? _____

Is your family connected with other groups, churches, or religious organizations? _____

_____

Has your child ever had difficulty with the police? _____yes _____no (explain if yes)

Has your child ever been on probation? _____yes _____no

Is your child employed? _____yes _____no

Additional comments, questions, or concerns: _____

_____

_____

Signature: _____ Date: _____