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## PERSONAL DATA / INTAKE: CHILD AND ADOLESCENT

Name:_____ Date:_____
Date of Birth:_____/_____/_____ Gender: _____

Ethnic Group (circle)
American Indian/Native Alaskan
Asian/Pacific Islander
Black/African American
Hispanic/Mexican/Latino
Caucasian
Multi-Racial

Current School or Daycare (if applicable)
Name:_____
Teacher:_____
School Counselor:_____
Phone #: _____ Grade: _____

**Family Contacts & Info**

Name of person(s) with whom the child presently lives _____ Relationship _____
Street_____ City/State _____Zip _____
Home #: _____ Work #: _____ Mobile #: _____ Email:_____

Name of other person(s) with whom child visits or lives_____ Relationship_____
Street_____ City/State_____ Zip_____
Home #: _____ Work #: _____ Mobile #: _____ Email:_____

Legal Guardian (if different from above):
Name:_____ Relationship _____ Phone# _____

Custodial Arrangement (if applicable) _____
Agencies involved with the family _____

Are there any firearms in the home where the child may reside? ___No ___Yes (If yes, please explain how these firearms are stored) _____

Is the family involved in any legal proceedings? If yes, what? _____
_____

**What is the present problem?**

_____
_____
_____
_____

When did this problem begin? _____
_____

How would you like the situation to change as a result of treatment? _____
_____
_____

Please check any of the following that apply now:

| | | | |
|---|---|---|---|
| __ Headaches | __Nightmares | __Lives in a make believe world | __ Sets fires |
| __ Dizziness | __Night terrors | __"Out of touch" with reality | __Doesn't obey |
| __Fainting Spells | __Tense | __Hears voices others don't hear | __Tells lies |
| __Fast Heartbeat | __Fearful | __Few or no friends | __Steals |
| __Rashes | __Worried | __Withdrawn | __Wanders |
| __Stomach Trouble | __Panicky | __Poor Social Adjustment | __Throws Tantrums |
| __No Appetite | __Sad or Unhappy | __Runs Away | __Bullying |
| __Weight Gain | __Tremors | __Anger Difficulties | __Easily Frustrated |
| __Weight Loss | __Aggressive | __Needs others too much | __Restless |
| __Bowel Disturbance | __Cruel | __Difficulty making Decisions | __Clumsy |
| __Soiling | __Selfish | __Problem with Attention Span | __Feels Inferior |
| __Wetting | __Destructive | __Poor School Behavior | __Feels bad about self |
| __Bladder Problems | __Fatigue | __Frequently feels Guilty | __Thinks about hurting self |
| __Sleeping Problems | __Immature | __Suicidal behavior and/or threats | __Fears going to scho |
| __Shy | __Lonely | __Worried about sex matters | |

__Otther_____

**Treatment History:** If the child has ever been seen before for mental health services (including psychiatric hospitalizations) please list below:

| | Who/Where | Dates | Please Describe |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |

Has the child ever engaged in suicidal or self-injurious behavior? If yes, please describe: _____
_____
_____

Has anyone in her/his family had psychological or psychiatric problems? If yes, please describe: _____
_____
_____

Has any relatives committed suicide? If yes, please describe: _____
_____

Has the child ever been a victim of abuse or maltreatment by an adult? If yes, please explain:_____
_____
_____

**Medical History**

Please list any current medical problems: _____

_____

Please list any medication allergies: _____

Please list any medication being used currently (both prescribed and non-prescribed): _____

_____

Has the child ever been hospitalized for medical reasons? ___ Yes ___ No

If yes, please describe _____

Please check if the child or any blood relatives have had any of the following:

| | | | |
|---|---|---|---|
| ___Cancer | ___Thyroid problem | ___Kidney trouble | ___Abortions |
| ___Diabetes | ___Other Hormonal Illness | ___High blood pressure | ___Miscarriages |
| ___Asthma | ___Epilepsy seizures | ___Eye Trouble | ___HIV Positive |
| ___Heart trouble | ___Head Injury | ___Neurological disease | ___Allergies |

Have there been any questions or concerns about your child's development? _____

_____

Is there anything else you would like to tell me? _____