Individual Child/Adolescent Intake Form

Child/Adolescent Information
Name: _____ DOB: _____
Address: _____
City/State/Zip Code: _____

Mother of Child: Personal Information
Name: _____ DOB:_____
Address: _____
City/State/Zip Code: _____
Phone (H): _____ Phone (cell): _____
Email: _____ OK to contact via email? _____
Employer: _____ Phone (W): _____
Copy of ID or Drivers License ☐

Father of Child Personal Information
Name: _____ DOB: _____
Address: _____
City/State/Zip Code: _____
Phone (H): _____ Phone (cell): _____
Email: _____ OK to contact via email? _____
Employer: _____ Phone (W): _____
Copy of ID or Drivers License ☐

Step Parent or Guardian of Child Personal Information
Name: _____ DOB: _____
What is your relation to the child: _____
Address: _____
City/State/Zip Code: _____
Phone (H): _____ Phone (cell): _____
Email: _____ OK to contact via email? _____
Employer: _____ Phone (W): _____

Referral Source:
If referred, name of group or person that referred you to counseling: _____
Were you referred directly to The Vine Wellness for counseling? ( ) Yes ( ) No

Annual household income(optional): _____ Currently meeting your bills? ( ) Yes ( ) No

Family Information

People living in the home:

Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

What languages are spoken in the home? _____
How many homes has the child lived in? _____
With whom does the child share a bedroom and/or bed with? _____
Who has legal custody of the child? _____

Relationship Status of the Parent/Guardian filling this out:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
In what year were the parents separated, if applicable? _____

Child's Development History

Did the mother of the child receive prenatal health care: ( ) Yes ( ) No
Any birth complications or problems? _____
_____
What was your child's birth weight? _____ Were eating/sleep patterns ____regular ____irregular?
What was your child's approach to new situations? ____ Positive ___ Withdrawn ____ Slow to warm up
What was your child's reaction to new stimuli? ____ Intense _____ Moderate _____Little _____ None
When trying new things would you describe your child as: ____ Adaptable ____ Slow to adapt
___ Unadaptable
How is your child disciplined in the home? _____
Any current troubles with sleeping? _____
Did/does your child co-sleep with anyone in the home, if so with who?_____
Any speech, hearing, or language difficulties? _____
_____
List all childhood illnesses, hospitalizations, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions:
_____
_____
_____

Special skills and talents of child

List hobbies, sports; recreational, musical, TV and toy preferences; etc.: _____
_____
_____

Education Information

Name of current school: _____ Grade: _____
Name of teacher: _____
How many schools has the child attended in the last 2 years? _____
Describe your child's academic performance over the past school year: _____
_____
_____
Is your child's behavior a problem in school? _____
Does (s)he use Special Education services? _____
If applicable, date of last ARD: _____

Current Health Information

List any chronic illnesses, genetic illnesses, allergies or handicaps: _____
_____
_____
Is your child currently being treated for any illnesses or medical problems? ( ) Yes ( ) No What type?
_____
_____
Current Weight _____ Height _____
Is your child taking any medications at this time? ( ) Yes ( ) No
List ALL current prescription medications and how often your child takes them: (if none, write none)
Medication Name Total Daily Dosage Estimated Start Date
_____
_____
_____
_____
Current over-the-counter medications or supplements:
_____
_____
Date and place of your child's last yearly check-up:
_____
Current Physician: _____
Phone: _____

<u>Family Psychiatric History:</u>

Has anyone in your child's family been diagnosed with or treated for:

Bipolar disorder ----------( )Yes ( )No	Schizophrenia ----------( )Yes ( )No
Depression ----------( )Yes ( )No	Post-traumatic stress ----------( )Yes ( )No
Anxiety ----------( )Yes ( )No	Alcohol abuse ----------( )Yes ( )No
Anger ----------( )Yes ( )No	Other substance abuse----------( )Yes ( )No
Suicide----------( )Yes ( )No	Violence----------( )Yes ( )No

If yes, who had each problem?
_____
_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No
If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

Has a relative ever been **hospitalized** for drug or alcohol use, or mental or emotional difficulties?

_____

_____

Child's Psychiatric History:

Has your child participated in counseling in the past? ( ) Yes ( ) No
Is your child currently involved in any other counseling, including lay counseling, spiritual counseling, counseling at school, and/or professional counseling? ( ) Yes ( ) No
Current or past mental health diagnoses, date of diagnosis and by whom:

_____

_____

Intensive outpatient treatment? ( ) Yes ( ) No If so, When: _____
Where? _____

Psychiatric Hospitalizations? ( ) Yes ( ) No If so, When: _____
Where? _____

Drug and Alcohol Treatment/hospitalizations? ( ) Yes ( ) No If so, When : _____
Where? _____

Caffeine Usage:

How many caffeinated beverages do you drink a day?
Coffee _____ Sodas _____ Tea _____ Energy Drinks _____

Tobacco History:

Has your child ever smoked cigarettes/E-Cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No If so, How often: _____
Has your child used chewing tobacco? ( ) Yes ( ) No

Alcohol and/or drug use:

Does your child drink alcohol? ( ) Yes ( ) No
If Yes, how often? _____

Extra-curricular Activities/ Exercise:

Does your child exercise regularly? ( ) Yes ( ) No
Is your child currently involved in any organized groups/ individual lessons? ( ) Yes ( ) No
If Yes, please list: _____

Trauma History:

Has there been any significant changes in your child's life in the past 18 months? ( ) Yes ( ) No
If yes, explain: _____

_____

Are you aware if your child has ever experienced any form of abuse: emotional, sexual, physical or by neglect? ( ) Yes ( ) No
If Yes, please describe when, where, by whom and if a CPS report was made _____
_____
_____
_____
_____
_____

Spiritual Life:
Does your child belong to a particular religion or spiritual group? ( ) Yes ( ) No
Name of congregation: _____
If yes, what is the level of your child's involvement?
_____
Do you find your child's involvement helpful during this time, or does the involvement make things more difficult or stressful for them? ( ) more helpful ( ) stressful

Mental Status Information
Has your child made any recent comments about suicide, not wanting to be around any more, or comments/signs of harming themselves in any way?
( ) Yes ( ) No

Has your child had any thoughts/comments, even once, in the past, including the past few days or weeks, of suicide or harming themselves in any way? ( ) Yes ( ) No

Has your child made comments about harming anyone else in any way? ( ) Yes ( ) No

Counseling Information
Describe the situation that brings you to seek counseling for your child: _____
_____
_____
_____

Describe what has already been done to resolve the situation: _____
_____
_____
_____

What do you hope for in resolving the situation? What will be different? _____
_____
_____
_____

Is there anything else that doesn't appear on this or other forms, but that is or might be important?
_____
_____
_____