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Child/Adolescent Intake Form

Name______________________________________ **Date** ________________

Date of Birth_____/_____/_____ Age _____

What problem(s) have led you and your family to seek help at this time?

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School:____

Grade _____________

Do you enjoy school? Y N

Describe any academic problems you have experienced in the past or currently:

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____

____

List any problems or conflicts you have had at school apart from academics:

____

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Social

Do you make friends easily? Y N

How many close friends do you have? ____

How many acquaintances? ____

How would you describe these friendships:

____

____

____

Clubs/ organizations

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____

Hobbies

____

Experience with mental health professionals

Have you received therapy in the past? Yes No

Whom have you seen?

____

____

____

____

Individual therapy _____ Group therapy _____

Quality of experience with therapist: (rate by circling a number) (Negative)1 2 3 4 5 (Positive)

Have you been in the care of a psychiatrist? Yes No

Whom have you seen?

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____

Quality of experience with psychiatrist: (rate by circling a number) (Negative)1 2 3 4 5 (Positive)

Do you experience or have diagnosis of?

Depression____ Anxiety ____ ADHD ____ Bipolar Disorder____ Suicidal Ideation____

Other____

Medications used for psychiatric problems:

____

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____

Other Health Information

This information is important for understanding your own personal health challenges.

Please **check** those that apply.

Heart disease ____ High blood pressure ____ Stroke ____ Diabetes ____

Thyroid disease (circle one) Hypothyroidism (low) Hyperthyroidism (high) Brain disorders: Seizures ____ Tumors ____ Infection ____ Injury ____

Lung disease ____ What kind? ________________________________

Kidney problems ____ Bladder problems ____ Liver disease ____

Indigestion/gastric reflux ____ Constipation ____ Inflammatory GI disease ____

Cancer ____ What part of body affected?_______________________________

Arthritis ____ Lower back pain ____ Joint pain ____ Migraine ____ Tension

headaches ____ Other chronic pain ____

What part of the body? ____

Surgeries (please list)

____

____

____

Childhood illnesses (such as middle ear infections, measles)

____

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