Adolescent Intake Form (Parent Form)

Today's Date_________

Child's Name: ____ Age: __________ Birthdate: _______________

Address: ____ Parent Phone number: ______________________

Is it ok to call, leave messages, and text this number? ____

Parent email address: ____ Is it ok to communicate via email? _______

Person completing form: _______________________________________ Relationship to child:_________________

	Full Name	Age	Living in home?
Child's Mother			
Child's Father			
Step Mother			
Step Father			
Siblings			
(Include Step and Half Siblings)			
Who else lives in the home other than listed above?			

Child was raised by:____

Describe the problems that the child is having (behaviors, feelings, attitudes, school performance, etc):

____

____

____

How long have these problems been going on? ____

Why do you think the child is having these problems? ____

Describe how these problems affect you and other family members: ____

____

What would you like to see done for the child? ____

What are child's interests? ____

Has child lost interest in activities that he/she usually enjoyed? ____

Does child work? ________________________ Hours per week? ___________________________

Symptoms: Circle the numbers that you believe describe the child

	How long ago did this start?	How often does it occur? Daily, times per week/month
1. Nervous habits		
2. Frequent headaches		
3. Frequent stomach aches		
4. Sleeping too much		
5. Sleeping too little		
6. Difficulty making/keeping friends		
7. Little interest in friends		
8. Disrespectful/argumentative		
9. Temper tantrums		
10. Ignores rules/chores		
11. Defies authority		
12. Threatening behavior		
13. Throws/breaks things		
14. Gets in physical fights		
15. Hurts animals		
16. Sets fires		
17. Steals		
18. Lies		
19. Breaks Curfew		
20. Runs away		
21. Skips School		
22. Doesn’t complete schoolwork		
23. Has problematic friends		
24. Acts before thinking		
25. Short attention span		
26. Unable to sit still		
27. “Clowns around” a lot		
28. Worries a lot		
29. Afraid/ fearful		
30. Seems insecure		
31. Withdrawn		
32. Shy		

33. Sad/depressed		
34. Cries frequently		
35. Drug or alcohol use		
36. Avoids family activity/contact		
37. Nightmares		
38. Acts spoiled		
39. Too interested in sex		
40. Disorganized/messy		
41. Self-harmful behavior (cutting, burning, etc)		
42. Poor eating habits		

Please explain further any items: ____

____
____
____
____

Has child ever expressed a wish that he/she were dead? If so, when? ______________________

Has child ever attempted to hurt him/herself? If so, when and how? _______________________

____

Describe any legal problems client has had: ___________________________________

School

Name of school: ______________________________ Grade: __________

Is child in any Special Education classes? _____________________________________

Does child have any learning disabilities? _____________________________________

Has child repeated any grades? ____

Describe child's attendance: ____

Describe child's academic performance: ______________________________________

Describe child's behavior in school: ____

Changes in behavior or academic performance? _________________________________

Previous Treatment

Has the child had previous mental health or substance abuse treatment?

When, where: ____

Reason: ____

Has child ever been in a psychiatric hospital?

Where, when:____

Reason: ____

Were any of these experiences helpful? _______________________________________

Health/Development

Is child in good physical health? ____

Does child have a history of medical problems or hospitalizations? _____________________

List medications (physical or mental health): ___

Was pregnancy desired? ___ Length of term: ___

Complications during pregnancy? ___

Any smoking, alcohol, or drug use by mother during pregnancy? ___

Describe child as an infant (happy, fussy, overactive, withdrawn, etc): ___

Age child took steps: ___ Spoke words: ___ Spoke sentences: ___

Toilet trained during day: ___ During the night: ___

Parent/Family Information

Education Level of Mother: ___ Employment: ___

Education Level of Father: ___ Employment: ___

Is there family history of any mental health issues (depression, anxiety, etc)? Please include parents, grandparents, siblings, aunts/uncles. ___

Is there family history of problems with alcohol or drug use? ___

How well do you get along with your child? ___

How well does your spouse/partner get along with child? ___

How does child get along with brothers/sisters? ___

How do you or your spouse/partner deal with misbehavior? ___

Has family ever been involved with Protective Services? ___

Are there any situations in the home that might have an effect on child's behavior? ___

Are you aware of how any issues that you may be struggling with have influenced your child? ___

What do you hope that your child will gain from treatment? ___

Parent Signature/date

Therapist Signature/date