Child and Adolescent Intake

Client Name:____ Date: ________________

Date of Birth: ____________

Identifying information:
Name/Relationship of person providing information: ________________________________
Name of legal guardian:____

Referral Source: ____

Reason for seeking treatment/presenting problem:

____
____

Is your child currently exhibiting, or has exhibited in the past, any of the following:

___Difficulties with attention/focus ___Hyperactivity or fidgetiness ___Behavioral issues at school
___Uncontrollable anger and rage ___Aggression toward others ___Rapid changes in mood
___Mood swings and irritability ___Destruction of property ___Learning disabilities
___Poor academic functioning ___Difficulty getting along w/peers ___Depression/isolation
___Anxiousness/excessive worry ___Self-injurious behavior ___Suicidal thoughts/behavior
___Difficulties with rules/authority ___Frequent lying, stealing ___Breaking laws
___Loss of interest ___Difficulty handling change ___Engaging in ritualistic behavior
___Difficulties with social skills ___Delay in language development ___Socially inappropriate behavior
___Using/abusing alcohol/drugs ___Hearing voices/seeing things that are not there
___Running away, threatening to ___Change in sleeping habits ___Argumentative
___Using/abusing alcohol or illicit drugs (Specify type:__________) ___Other:

Please provide some details on the nature of the problem(s) noted above: ____________________
____
____

How long has your child been experiencing these problems: ___________________________
Are there any major stressors currently or in the recent past that may be affecting your child's current problems? ____

Past and current psychiatric history:
___ADD/ADHD ___Oppositional/Defiant Disorder ___Conduct Disorder ___Depression
___Anxiety Disorder ___Bipolar Disorder ___ Autism/PDD ___Asperger's Disorder
___Eating Disorder ___Tic /Tourette's ___Schizophrenia ___Obsessive-Compulsive Disorder
___Using/abusing alcohol or illicit drugs ___Other:

Please provide a brief history, if known, including the age of onset and the treatment for each of the conditions marked above: ____

Client Name: ______________________________ **Date:** ______________

Please provide the name and contact information of the previous Physician/Therapist:

____

Past Psychiatric Hospitalizations: ___None ___Unknown ___Yes (provide the information below for each time)

Name: ____
Date (approx.): ____
Reason for admission: ____
How many days?: ____

Family History: ___None _____Unknown ______Yes (Check all that apply)

___Depression ____Suicide ___Bipolar Disorder ___Schizophrenia ___Anxiety/Panic Disorder
___ADD/ADHD ___Alcohol Abuse ___Cocaine Abuse ___Other drug abuse (please specify_____)
___Family violence ___Anger ___Eating disorder ___Autism/PDD ___Weight problems
___Diabetes ___High blood pressure ___Heart Disease ___Other: ______________

For each of the conditions marked, please tell the relationship to the client:

____
____

Health and Developmental History:

How would you describe the health of your child? ____Excellent ___Good ____Fair ____Poor
Any allegies to medications ___None _____Yes (provide details): ___________________________
Any allergies to food: ____None ____Yes (provide details): ______________________________
Date of last medical checkup/issues: ____
Current pediatrician/PCP Name: _____________________ Contact: ______________________
Has your child had, or currently have, any of the following?

___Asthma/allergies ___Seizures/Epilepsy ___Heart defects/heart disease ___High Cholesterol
___Meningitis/Encephalitis ___Anemia ___Hearing problems ___Frequent ear infections
___Kidney Problems ___Liver problems ___Head injury (loss of consciousness, concussion, etc.)
___Bedwetting ___Any genetic/metabolic disease:
___Any other serious illness (s):

For each of the conditions marked, please give details on current status, severity, age of onset:

____
____

Current Medications? ____None ____Yes, please list below, including medication name, dose/frequency, when started, reason and prescribing physician:

____
____
____

Client Name: ______________________________ Date: ________________

Pregnancy and Birth History: __No history available __Partial/full history available (please provide info below)
Duration of pregnancy? _____weeks/months Birth weight? ______________
Mother's age at birth? ______________ Did mother receive prenatal care? ____________
Any problems during pregnancy? (if yes, please explain)

____

Any problems during birth? (If yes, please explain)

____

Developmental milestones: __No history available___Partial/full history available (please provide info below)
___Within normal limits (to the best of my knowledge, details not available)
Sat up without help at ____months; Spoke first words at ___months; Spoke sentences at ____months;
Crawled at ____ months; Spoke short phrases at ___months; Walked alone at ___ months;
Fully bladder trained at ___months; Fully bowel trained at _____ months;

Any other information regarding early childhood/development? (physical issues, behavioral issues, social issues, etc)

____
____

Behavioral History:
Infancy: During your child's first few years of life, were any of the following present to any significant degree?

___Did not enjoy cuddling
___Difficult to calm
___Frequent head banging
___Colicky
___Excessively irritable
___Constantly getting into everything
___Difficult nursing
___Excessively restless
___Poor eye contact
___Did not respond to name or speech of caregivers
___Diminished sleep

Comments: ____

Toddler through five years of age:
How active has your child been from an early age?
___Hyperactive ___Very active ___Age appropriate___Less active than peers ___Mostly inactive ___Other
How well was your child abuse to maintain focus, concentrate or pay attention to tasks?
___very well ___fairly well ___not very well ___couldn't focus at all ___ other: ______________
How well was your child able to deal with transition, change, or when denied his/her own way?

____

Whether happy/unhappy, how strong were your child's feelings when exhibited?

____

What was your child's basic mood? _________________________________
Did your child exhibit frequent or rapid changes in mood or temperament?

____

How predictable were your child's patterns of activity level, sleep, appetite, etc.?

____

Client Name: ______________________________ Date: ________________

Educational Information:

Grade: __________ What school do you attend? ______________________________

Academic Grades: ______________________________

Do you have a current 504 plan in place? ___No ___Yes (Describe) ______________________________

Academic Attainments, Difficulties? ______________________________

Living situation: ______________________________

Family/Social Relationship History (including relationships with parents, siblings, significant other(s) if applicable):

____

____

Sexual History, Sexual acting out history if applicable:

____

____

History of Abuse/Neglect: ___No ___ Yes (please describe): ______________________________

____

History of Trauma: ___No ___Yes (please describe): ______________________________

____

History of Domestic Violence ___No ___Yes (please describe): ______________________________

Chemical Use History:

Have you ever used any illegal drugs? ____No ____Yes (describe frequency, amount, age of first use below):

____

____

Do you use tobacco products? ____No _____ Yes (describe frequency/amount):

____

Do you drink alcohol? ____No _____Yes (describe frequency/amount, age first use): ______________

____

Please list any other substances you take: ______________________________

Have any of your family members or significant relationships had a problem with drugs or alcohol? If yes please describe: ______________________________

Leisure/Recreational/Personal Self-care: Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, church activities, diet/health, fishing, traveling, etc.):

____

Occupational History: ____No ___Yes (If yes, please list employer, dates, title, reason left job and how often did you miss work for each job):

____

____

Client Name: ______________________________ Date: ______________

Legal History:

List all of the client's arrests (charges), dates of arrests and the outcomes, if applicable:

____

____

Have either of the child's/teen's parents been incarcerated? ______________________________

Have any other family members been incarcerated? ______________________________

Please describe any past/present services or systems that have been involved in your life (e.g., CPS, Government support, school counseling, etc.)

____

____

Military History: _____No _______Yes (If yes, please describe the following: branch, discharge, rank at discharge, how military experience affected your life): ______________________________

____

Client/Client Family Strengths/Needs/Abilities/Preferences: ______________________________

____

____

Initial Goals for Counseling: ____

Mental Status:

Dress/Grooming ___Neat/clean ____Disheveled _____ Inappropriate: ______________________

Eye Contact: ___Good ___Fair ___Poor ___Avoids eye contact

Mood: ___Appropriate ___Irritable ___Elevated _____Anxious ___ Depressed ___Other: ____________

Affect: __Appropriate ___Flat ____Incongruent ___Inappropriate: ______________________

Activity level during interview: ___Calm ___Slowed ____Restless ___Hyperactive

Attitude Toward Interview: ___Cooperative ____Uncooperative

Insight: Awareness of problems, consequences and causes ___Excellent ___Fair ___Poor

Behavioral Health/Medical Provider Coordinator of Care

Please complete this form so I may communicate with our Primary Care Physician or other medical provider. If you do not have a physician, or do not want to disclose information to any medical provider, please check the box at the bottom and sign.

Client Information

Client's Name (the person being seen for counseling): ____________________ DOB: ___/___/___ Type of Insurance: ____________________

If a client is a minor, parent's or guardian's name: ____________________ Daytime Phone No: ____________________

Client's home address: ____________________

Primary Care Physical or Medical Provider Information

___ Client does not have a medical health provider.

PCP or Medical Provider: ____________________ Address: ____________________ Medical Provider Phone No. ____________________

Current Treatment and Medications: ____________________ Medical Provider FAX No: ____________________

Behavioral Health Provider Communication

For office use only – Clinician will complete this section to communicate important information about the client to the client's medical provider

Behavioral Health Provider: ____________________ Address: ____________________ BH Provider Phone No: ____________________

Client Diagnosis ____________________ Comments: ____________________

Risks/Concerns ____________________ Comments: ____________________

Client Authorization

I understand that I am not required to sign this authorization as a condition of receiving services from Nakeisha Q. Washington M.A.,LPC ;NCC . The reason for disclosure is to facility continuity and coordination of treatment and may include the diagnosis of mental health disorders. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. In any event, this consent shall expire one (1) year from the date signed unless revoked earlier.

Expiration date: ____________________

I give my authorization:

_____ To release any applicable mental health information to my PCP and/or medical provider designated above.

_____ To release any applicable medical information from my PCP and/or medical provider to my behavioral health provider.

_____ I DO NOT give my authorization to release any information to my PCP and/or medical provider.

Client or parent/Guardian Signature: ____________________ Date: ____________________

For office use: Date faxed to PCP/Medical Provider ____________________ By: ____________________ Notes: ____________________

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR pat 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose.

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Nakeisha Q. Washington M.A.,LPC/NCC