Serenity Life Resource Center
Growing Community Together

# INTAKE INFORMATION-Child/Adolescent

Welcome to Serenity Life Resource Center. Please answer all information as completely as possible. If applicable, both mother and father should complete together. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your child's counselor will discuss your responses with you after he/she has reviewed the form.

Child's Name _____ Date of First Visit _____

Completed by _____ Relationship to Child _____

Date of Birth _____ Age _____ Sex: M F

Present Address _____

City _____ State_____ Zip_____

Employer _____

Home ( ) _____ Cell ( )_____ Other ( )_____

May I leave a message on an answering machine? ☐Yes ☐No

Work ( )_____ May I contact you at work? ☐Yes ☐No

Best Time and Place to Call _____

Email address _____

May I send appointment reminders and receipts through email? ☐Yes ☐No

Child's Legal Guardian (Managing Conservator) _____

(If the child is not living with both natural parents, both adoptive parents, or only living parent, the clinic requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservators and signature page, before the child is seen).

Religious Preference _____

Parent/Guardian's Name _____

Biological or Adopted _____ If adopted, child's age at adoption _____

Child's Ethnic Background _____ Primary Language Spoken at Home _____

If child is not living with both natural parents:

Were parents married? _____ When? _____

Have parents divorced? _____ When? _____

Is either natural parent deceased? _____ When? _____

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Other marriages? _____

Briefly explain any special living circumstances (foster-care, custody arrangements, visiting rights, etc.)

_____
_____
_____

How long has the child resided at the present address? _____

Does the child share a bedroom with anyone? Y N If yes, with whom? _____

**Education**

Child's School _____ # Years attended _____ Grade _____

Teacher _____ School Counselor _____

Who referred you to this office? _____

**Client Information**

Has your child had any counseling or are they currently in any type of counseling? _____

Name, address and phone number of current therapist _____

_____

How successful did you find previous counseling? _____

_____

Is child currently seeing a psychiatrist? Y N

If yes, name, address, and phone # of psychiatrist _____

_____

Is child taking any medication? Y N

If yes, what type of medication does the child take and what is the medication for?

_____
_____

Does it help? _____

When was child's last physical exam? _____ Given by whom? _____

What were the results? _____

**Presenting Concerns**

What is your main concern about your child?

_____
_____
_____

How long has this concern existed? _____

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In what setting does it occur? (circle all that apply)

Home School Church Sports Neighborhood Public place Other _____

Does this child have any academic concerns? Y N

If yes, please explain _____

_____

Has he/she ever repeated a grade? _____ Which grade? _____

Has there been any abuse of the child? (please circle all that apply)

Physical Verbal Sexual Neglect

Please explain anything that was circled _____

_____

Would this child say that he/she had many friends? Y N

Please explain _____

What are the typical difficulties this child has with brothers and/or sisters? _____

_____

How does the child express anger? _____

Was there a time when the child seemed to be doing well in school and/or home? Y N

Describe _____

What does the child do well? _____

_____

How will you know that things are changing as the process is ongoing? _____

_____

What do you expect will be different when therapy is completed? _____

_____

**Developmental History**

**Pregnancy and Delivery:**

Length of pregnancy: _____ weeks Birth weight: _____lbs, _____oz

Please describe any pregnancy complications: _____

_____

Drug/Alcohol use during pregnancy? Y N

If yes, please explain: _____

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**Early Childhood:** Check one in each column indicating when child showed development in each area.

Child Walked
__ less than 12 months
__ 12-24 months
__ 24-36 months
__ over 36 months
__ has never walked

Child Spoke Words
__ less than 12 months
__ 12-24 months
__ 24-36 months
__ over 36 months
__ has never spoken words

Spoke Sentences
__ less than 12 months
__ 12-24 months
__ 24-36 months
__ over 36 months
__ has never spoken sentences

Child First Trained for Urination
__ less than 12 months
__ 12-24 months
__ 24-36 months
__ 3-5 years
__ not yet trained

Child First Trained for Bowels
__ less than 12 months
__ 12-24 months
__ 24-36 months
__ 3-5 years
__ not yet trained

Since Initial Toilet Training
____ Frequent wetting during day
____ Frequent wetting during night

Since Initial Toilet Training
____ Frequent soiling during day
____ Frequent soiling during night

Explain any of the above: _____
_____

**Puberty:** Onset of puberty (breast development, menstruation, pubic hair, facial hair)

__ under 10 years
__ 10-12 years
__ 12-14 years
__ 14-16 years
__ over 16 years
__ no development

**Illness and Diseases:** Please check any illness or disease which child has had.

__ asthma
__ eczema
__ diabetes
__ cancer
__ measles
__ mumps
__ chicken pox
__ diphtheria
__ scarlet fever
__ polio
__ cerebral palsy
__ lead poisoning
__ encephalitis
__ tuberculosis
__ heart disease
__ influenza
__ migraine headaches
__ undescended testicles
__ high blood pressure
__ low blood pressure
__ sinusitis
__ appendicitis
__ heart surgery
__ tonsillectomy
__ convulsions
__ brain injury
__ fainting
__ dizziness
__ meningitis
__ broken bone
__ others (write in)
_____
_____
_____
_____
_____

**Hospitalizations:** Please list any hospitalizations, age and length of stay.

| Conditions for which hospitalized | Age | Length of Stay |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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_____ _____ _____

**Social & Behavioral:** Please check the items the child has difficulty with.

| | | |
|---|---|---|
| ___ auditory | ___ focus on objects; not people | ___ physical aggression |
| ___ bed wetting | ___ forgets | ___ rocking body |
| ___ blanking out | ___ giving up | ___ shyness |
| ___ breath holding | ___ habits | ___ sibling conflict |
| ___ can't fall asleep | ___ head banging | ___ sleep walking |
| ___ clumsiness | ___ hyperactivity | ___ social isolation |
| ___ constipation | ___ impulsivity | ___ slowness to learn |
| ___ coordination | ___ interrupted sleep | ___ soiling |
| ___ dangerous behavior | ___ mannerisms | ___ speech |
| ___ daredevil behavior | ___ nail biting | ___ stubbornness, rigidity |
| ___ diarrhea | ___ night terrors | ___ tantrums |
| ___ early waking | ___ nightmares | ___ thumb sucking |
| ___ eating | ___ verbal aggression | ___ fears |
| ___ vision | ___ other language | ___ other (describe) |

**Family History**

Check all of the following family concerns that apply currently or in the last 6 months:

__ Marital difficulties
__ Aging grandparents
__ Alcoholism
__ Serious illness of child
__ Serious illness of relative
__ Older sibling leaving home
__ Recent death in family
__ Recent death of friend
__ Drug addiction in family
__ Financial problems
__ Birth of a sibling
__ Step parent in the home
__ Move to a new home
__ Traumatic experience
__ Move to a new school
__ Other (specify) _____

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Has there been anyone in either parent's family who has been treated for mental illness? Y N

If yes, please explain: _____

Has anyone in either parent's family been prescribed medication for depression, bipolar disorder, or anxiety? Y N

If yes, please explain: _____

Has anyone in either parent's family been treated for alcoholism and drugs? Y N

If yes, please explain: _____

Describe briefly any special interest, hobbies, and recreational activities in which family members partake:

Child: _____

Mother: _____

Father: _____

Brothers/Sisters: _____

Please list all those living in child's home:

| Name | Relationship | Date of Birth | Employer/School |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please list all other persons closely involved with child but not living in home:

| Name | Relationship | Date of Birth | Employer/School |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Describe an important family value _____

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_____

How would you describe the child as a person? _____

_____

_____

Name of adult completing this form: _____

Relationship to child: _____

Parent Signature_____ Date: _____

Parent Signature_____ Date: _____

Therapist Signature_____ Date: _____