Living Vine Counseling, LLC

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CHILD/ADOLESCENT INTAKE FORM

All information is strictly confidential

Child's Name _____Today's Date_____

Nickname (if any) _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Age _____ Sex _____Date of Birth _____

School_____ Grade _____ Teacher's Name_____

May I contact the teacher or school counselor?_____

Primary Doctor_____

May I contact the doctor?_____

Who does your child live with? _____

Does he/she have any siblings?_____

What is the relationship like with their siblings?

_____

Do you have any spiritual affiliation? _____

Referred By: _____

Parent Information

(If necessary, please indicate primary custodian and stepparent's name)

Mother's Name _____
Check One: _____Biological _____Step _____Foster

Employment _____Employment Phone _____

Home Phone _____ Cell Phone _____

Father's Name _____
Check One: _____Biological _____Step _____Foster

Employment _____ Employment Phone _____

Home Phone _____ Cell Phone _____

If child has parents who are divorced, who has primary custody?_____

May I contact the other parent?_____

CURRENT PROBLEMS

What problems bring your child here for counseling?

_____

_____

_____

How and when did the problem begin?

_____

_____

_____

Check all that your child is currently experiencing:

EMOTIONAL:
____ Anxiety
____ Depression
____ Change in personality
____ Frustration
____ Anger
____ Extreme mood swings
____ Crying spells
____ Hyperactivity
____ Irritability
____ Feelings of hopelessness
____ Panic spells
____ Fearfulness

BEHAVIORAL:
____ Loss of energy
____ Bedwetting
____ Hurting self
____ Aggression towards others (biting, pushing, hitting)
____ Violence toward animals
____ Excessive shyness
____ Biting nails
____ Not listening/following the rules

EATING:
____ Increased appetite ____ Decreased appetite
____ Anorexia
____ Bulimia (self-induced vomiting or laxative use)

SLEEPING:
____ Early waking
____ Snoring
____ Sleepwalking
____ Difficulty falling asleep
____ Nightmares
____ Daytime sleepiness

INTELLECTUAL:

____ Poor concentration
____ Slowness of thinking
____ Problems understanding what other people say
____ Problems with reading or spelling
____ Problems with memory
____ Difficulty organizing or planning
____ Problems completing schoolwork
____ Difficulty finding the right words
____ Use of wrong/ inappropriate words

THOUGHT:

____ Racing thoughts
____ Guilty feelings
____ Phobias
____ Recurrent thoughts of death
____ Fears of hurting others
____Unusual thoughts
____ Recurrent Nightmares
____ Suicidal thoughts

OTHER CHILD CHARACTERISTICS

□ Argues, "talks back," smart-alecky, defiant
□ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
□ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
□ Complains
□ Dawdles, procrastinates, wastes time
□ Difficulties with parent's paramour/new marriage/new family
□ Dependent, immature
□ Developmental delays
□ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
□ Distractible, inattentive, poor concentration, daydreams, slow to respond
□ Drug or alcohol use
□ Failure in school
□ Fire setting
□ Hypochondriac, always complains of feeling sick
□ Immature, "clowns around," has only younger playmates
□ Interrupts, talks out, yells
□ Lacks respect for authority, insults, dares, provokes, manipulates
□ Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
□ Likes to be alone, withdraws, isolates
□ Lying
□ Need for high degree of supervision at home over play/chores/schedule
□ Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness,
□ Recent move, new school, loss of friends
□ Relationships with brothers/sisters or friends/peers are poor
□ Rocking or other repetitive movements
□ Runs away
□ Sad, unhappy
□ Self-harming behaviors—biting or hitting self, head banging, scratching self
□ Speech difficulties
□ Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
□ Swearing, blasphemes, bathroom language, foul language
□ Temper tantrums, rages
□ Thumb sucking, finger sucking, hair chewing
□ Tics—involuntary rapid movements, noises, or word productions
□ Teased, picked on, victimized, bullied
□ Truant, school avoiding

Other Symptoms not previously mentioned:

_____

_____

_____

_____

EDUCATION HISTORY

1. Last year completed in school? _____ Present_____ G.P.A_____

3. Did your child ever skip any grades? If yes, which?

_____

4. Did your child repeat or fail any grade(s)? If yes, which?

_____

5. Did he/she have difficulty learning to speak, read, write, or spell? If yes, which?

_____

6. Has your child ever been placed in any special education classes? If yes, which?

_____

7. Were you ever told that your child were hyperactive? If yes, by whom?

_____

8. Were you ever told that your child had Attention Deficit Disorder? If yes, by whom?

_____

9. Were you ever told that your child was Dyslexic? If yes, by whom?

_____

10. Were you ever told that your child had a learning disorder? If yes, by whom?

_____

11. How does your child get along with other children?_____

_____

How does your child get along with adults/authority?_____

_____

12. Has your child ever been suspended or expelled from school for disciplinary reasons? If yes, when and why?

_____

_____

13. Has your child ever had an intelligence test? YES_____ NO_____ If yes, when and by whom?_____

MEDICAL HISTORY

Medical Physician

Primary Care Physician's Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax#_____

Any complications with your pregnancy and child's birth? _____ YES _____ NO

If so, list here: _____

MEDICATIONS THAT YOUR CHILD IS CURRENTLY TAKING

	Medication	Strength	Times Per Day	Physician
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

List other medications that your child takes occasionally:

1. _____
2. _____
3. _____
4. _____

List any allergies or medical conditions your child has below:

1. _____
2. _____
3. _____

PSYCHIATRIC HISTORY

Has your child ever been treated for psychiatric reasons? YES _____ NO _____

If Yes, please complete the following:

Clinician's Name _____

Clinician's Credentials _____

Clinician's Address _____

City _____ State _____ Zip _____

Has your child ever received psychological testing before: YES _____ NO _____ If yes, by whom and when?

_____

Has your child ever been hospitalized for psychiatric reasons? YES _____ NO _____ If yes, by whom and when?

_____

Have you ever attempted suicide? YES _____ NO _____ If yes, how many times and when?

_____

Has your child ever been placed on psychiatric medications? YES _____ NO _____
If yes, please name the medication, dosage and child's response to the medication.

_____

_____

Has your child ever been in counseling before?_____

What was your experience with the previous counselor?_____

Is there a family history of any of the following psychiatric problems?

	Problem	**Relative**
_____	Depression	_____
_____	Mania	_____
_____	Suicide or suicide attempts	_____
_____	Anxiety or panic attacks	_____
_____	Obsessive compulsive disorders	_____
_____	Eating disorders	_____
_____	Paranoia	_____
_____	Schizophrenia	_____
_____	Others (Be specific)	_____

LEGAL HISTORY

Has your child ever been arrested? YES ____ NO _____ If yes, when/why?

_____

_____

Has your child ever been on probation? YES ____ NO _____ If yes, when and why?

_____

_____

If your child is on probation, please provide probation officer's name and number:_____

SUBSTANCE ABUSE HISTORY

Has your child ever abused alcohol or drugs? YES ____ NO _____ If yes, what/when/how often/treatment?

_____

_____

_____

ABUSE/TRAUMA HISTORY

Please describe any abuse or traumatic events that your child has suffered.

_____

_____

_____

Did your child receive any counseling for these events? _____ If yes, when/with whom/for how long?

_____

_____

Please feel free to add any information that you feel is relevant to your child and that may assist me in treating your child.

_____

_____

Signature:_____ Date: _____