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Child/Adolescent Initial Evaluation (Session #1) _____________

Please fill out this intake evaluation completely. Your information will be held in strict confidence according to state confidentiality laws.

Child's full name:____

Date of birth:_______________ Gender:______ Race/ethnicity:__________________

Child's Address:____

City/State/Zip:________________________________Phone number:__________________

Parent email address: ____

Presenting Issues

Adult providing intake information: ____

Please state who referred, or suggested, the idea of therapy for your child: ____________
____

Is your child (circle one): Biological/Adopted/Foster

If Adopted or Foster, please provide relevant details such as place of adoption, age at which adopted or began foster care:

____
____
____
____

Please state what concerns you have about your child at this time and how long you have been concerned. Please explain in detail, noting your child's particular symptoms, as well as their intensity and frequency: ____

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Please explain in detail any high-risk behaviors your child may be currently engaging in, or has engaged in, in the past (drug/alcohol use, sexual activity, running away, etc.):
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____
____

Please explain in detail any *legal* problems your child currently has, or has had in the past (involvement with Juvenile Services /court/ probation, etc.) ________________________
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____

Please list your child's strengths or areas of success: ______________________________
____
____

Please check activities your child is engaged in outside of school and frequency per week:

- Sports ____________________________________
- Music ____________________________________
- Martial arts ________________________________
- Art ____
- Dancing ____
- Tutoring ____
- Screen time ____
- Cultural/Religious classes ______________________________
- Other (please list) _____________________________

Please check activities you engage in together with your child, and approximate time spent per week:

- Unstructured play _________________________
- Board games ____________________________
- Outdoor play _____________________________
- Music/Singing/Dancing __________________________
- Meals __________________________________
- TV/Movies ______________________________
- Video games (describe kind of games) ______________________________

Please state all methods of discipline you use with your child and if these methods have successfully worked (changed the behavior):______________________________________

Please state what you hope to achieve, improve or make different through counseling:

Family Dynamics

If known, please list all disorders and conditions that apply within your child's biological family structure, including those of siblings, parents, grandparents, aunts, uncles, cousins, etc. (depression, anxiety, substance abuse/addiction, genetic disorders, neurological disorders, emotional/physical/sexual abuse, etc.):

Please state if there have been any recent stressors or changes in your environment which may be affecting your child (divorce or marital problems, death in the family, move to a new home / school / or neighborhood, etc.):

Parent's Demographics

Current caretakers:

Mother's name

Birthdate/age

Full address

Home phone #

Work/cell phone #

Best # to reach you at

Occupation

Father's name

Birthdate/age

Full address

Home phone #

Work/cell phone #

Best # to reach you at

Occupation

Employer____________________ _______ Employer__________________________________

If child resides with someone other than biological parents (adoptive parent, foster parent, relative, biological mother and step-father, etc.), please explain this arrangement in detail below. **A copy of custody arrangements and legal documents will be required**:
____
____
____
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Please list all individuals living in your child's home, who these individuals are in relation to your child, and each individual's age: ________________________________
____
____
____

Please state your child's legal guardian:____

Please list an emergency contact for you and your child with full name and telephone numbers:____
____

Please note if you have any particular religious or spiritual beliefs that you would like incorporated into the counseling process: ______________________________________
____
____

Child's Developmental and Medical History

Please list any problems during pregnancy and/or delivery of your child: _____________
____
____

Please state if your child was exposed to inutero stressors (mother under emotional stress, mother smoking cigarettes, drinking alcohol or having abused drugs while pregnant, etc.):
____
____

Please classify your child's early temperament (e.g., easy, quiet, stubborn, shy, difficult, over active, etc.):

____

____

Please list any developmental delays or problems your child had as an infant and toddler (e.g., weaning, walking, sitting up alone, toilet training, talking): ____________________

____

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Please list any problems your child has had, or currently has, with sleep, eating habits, or elimination (e.g., difficulty with urination, having normal bowel movements, or soiling undergarments):____

Please list any medical conditions your child currently has, or has had in the past (e.g., ear infections, allergies, etc.)

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Please detail all of your child's ER visits, hospitalizations and surgeries (including child's age, reason, and length of stay): ____

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Please list any medications your child *routinely* takes, or has taken in the past, and the reason for this medication: ____

____

____

Please list your child's pediatrician with address and telephone number: ______________

____

____

Please note the last time your child had a physical exam: ___________________________

____

Child's School History

Please state your child's current grade, school, and primary teacher:

____

____

____

Please explain any identified special needs your child has at his/her school (e.g., 504 or individualized educational plan, psychoeducational testing results):________________

____

Please detail your child's school history below:

Place	**Date**	**Location**	**Any problems?**	**Reason for Leaving**
Daycare				
Preschool				
Kindergarten				
Grade 1				
Grade 2				
Grade 3				
Grade 4				
Grade 5				
Grade 6				
Grade 7				
Grade 8				
Grade 9				
Grade 10				
Grade 11				
Grade 12				

Other Providers for child: (if applicable)

Please list *all current providers/agencies* your child is involved with for counseling or mental health purposes. Please list the name of provider, telephone number and what services you and/or your child are receiving:

____
____
____
____

Please list any *former providers/agencies* who have seen you and/or your child for counseling or mental health treatment, including the diagnoses your child received, when these services were received and from whom received: ____________________________
____