PSYCHOLOGICAL & COUNSELING SERVICES, PC

NEW CLIENT INTAKE FORM (CHILD OR ADOLESCENT)

TO BE COMPLETED BY THE PARENT/ GUARDIAN. PLEASE PROVIDE THE FOLLOWING INFORMATION.

TODAY'S DATE:_____

CHILD'S NAME:_____ **DATE OF BIRTH**:_____
RACE/ETHNICITY:_____ **RELIGIOUS IDENTIFICATION (IF ANY):**_____
SCHOOL/ GRADE:_____

PRESENTING PROBLEM/ REASON FOR APPOINTMENT:_____
_____
_____
HAVE YOU EVER SOUGHT HELP FOR THIS CONCERN BEFORE? IF SO, WITH WHOM? WHEN?_____
_____

PARENT NAME(S):_____
PARENT EMPLOYMENT, POSITION: _____
_____
PARENT RELATIONSHIP STATUS: □ MARRIED □ PARTNERED □ DIVORCED/ SEPARATED
NAME OF PARTNER/ SPOUSE:_____ DURATION OF RELATIONSHIP:_____
CHILD'S SIBLINGS (NAMES, AGES, GRADES):_____
_____
CUSTODY STATUS (IF APPLICABLE):_____
LIST EVERYONE WHO LIVES AT YOUR HOME:_____
DESCRIBE THE HOME ENVIRONMENT (CURRENT AND PAST):_____
_____

PRENATAL/ DEVELOPMENTAL HISTORY
IS YOUR CHILD ADOPTED?____ IF YES, DO YOU HAVE ANY INVOLVEMENT WITH THE BIRTH PARENTS?____
COMPLICATIONS DURING PREGNANCY/ DELIVERY?_____
PARENT SUBSTANCE ABUSE DURING/ POST-PREGNANCY?_____
UNUSUAL CHILDHOOD DEVELOPMENT/ MILESTONES?_____
ANY HISTORY OF SIGNIFICANT TRAUMA?_____
PHYSICAL ABUSE?_____ SEXUAL ABUSE?_____ DOMESTIC VIOLENCE BETWEEN PARENTS?_____

ACADEMIC HISTORY

CURRENT GRADE POINT AVERAGE (IF UNKNOWN, DESCRIBE TYPICAL GRADES):_____
WHAT IS SCHOOL LIKE FOR YOUR CHILD?_____
ACADEMIC STRENGTHS AND WEAKNESSES_____
ANY HISTORY OF ATTENTION OR BEHAVIOR PROBLEMS?_____
ANY DIAGNOSED LEARNING OR SPEECH DISABILITIES?_____
PARTICIPATION IN RESOURCE, SPECIAL EDUCATION, OR GIFTED PROGRAMS?_____
FAMILY HISTORY OF ACADEMIC/ LEARNING PROBLEMS?_____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN:_____ DATE OF LAST CHECKUP:_____
CURRENT MEDICATIONS, REASON TAKING, PRESCRIBING DR.:_____
_____
CHRONIC ILLNESSES?_____
SURGERIES PAST, PLANNED?_____
EMERGENCY ROOM TRIPS?_____

PSYCHIATRIC HISTORY

PRIOR COUNSELING, CLINICIAN SEEN:_____
CURRENT OR PAST PSYCHOTROPIC MEDICATIONS:_____
HOSPITALIZATIONS/ TREATMENT STAYS (DATE, LOCATION):_____
PAST DIAGNOSES:_____
PAST SUICIDE ATTEMPTS:_____
SUBSTANCE USE/ ABUSE HISTORY:_____

LEGAL HISTORY

PAST LEGAL CHARGES/ CONVICTIONS:_____
PENDING CHARGES:_____
CONDUCT PROBLEMS (fighting, lying, stealing):_____
CURRENT DIVORCE/ CUSTODY ACTIONS (INCLUDE WHEN INITIATED AND BY WHOM):_____
_____

INTERESTS AND ABILITIES

CHILD'S THREE PRIMARY INTERESTS:_____
GENERAL STRENGTHS:_____
WEAKNESSES:_____
SPORTS, CLUBS, AND EXTRACURRICULAR INVOLVEMENT, PAST AND PRESENT:_____
_____

SYMPTOM CHECKLIST

Place a check mark next to the symptoms that you are experiencing. For EACH symptom checked, please note the severity (1-10 from least to most problematic) and how long you have been experiencing this.

- □ Depressed mood
- □ Feeling hopeless
- □ Social withdrawal
- □ Lack of interest in previously enjoyed activities
- □ Changed sleep patterns (too much or too little)
- □ Changed appetite (too much or too little)
- □ Difficulty concentrating

- □ Irritability
- □ Fatigue
- □ Mood swings
- □ Recklessness
- □ Thoughts of suicide
- □ Suicide attempts
- □ Self-harm (cutting, self-mutilating)

- □ Obsessive thoughts
- □ Social anxiety
- □ Panic attacks (check relevant symptoms):
  - o palpitations, pounding heart, or accelerated heart rate
  - o sweating
  - o trembling or shaking
  - o sensations of shortness of breath or smothering
  - o feeling of choking
  - o chest pain or discomfort
  - o nausea or abdominal distress
  - o feeling dizzy, unsteady, lightheaded, or faint
  - o feelings of unreality or being detached from oneself
  - o fear of losing control or going crazy
  - o fear of dying
  - o numbness or tingling sensations
  - o chills or hot flashes

- □ Careless, poor attention to details
- □ Difficulty sustaining attention
- □ Unable to listen to others
- □ Difficulty organizing
- □ Tend to avoid effortful tasks
- □ Often lose necessary things
- □ Easily distracted

- □ Forgetful in daily activities
- □ Fidgety, unable to sit still
- □ Always on the go
- □ Acts as if driven by motor
- □ Talking excessively
- □ Difficulty waiting turn
- □ Impulsive/ acts without thinking first

Other symptoms not noted above:_____
_____
_____
_____

Anything else that would be helpful to know:_____
_____
_____