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Youth Intake

Demographic Information

Client's Name:_____Date of Birth:_____ Age: _____ Grade: _____
Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Gender: _____ School Attending:_____
Referral Source: _____
Email address: _____

Family & Social History

Individuals residing in the home:

Mother/Stepmother/Other:_____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Occupation:_____ Employer: _____
Email address: _____ Years w/child: _____
Relationship with child: _____

Father/Stepfather/Other:_____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Occupation:_____ Employer: _____
Email address: _____ Years w/child: _____
Relationship with child: _____

Children/Siblings in the home:

How many children reside in the home? *These include halfsiblings and stepsiblings*_____

Name	Father	Mother	DOB	Psych concerns?

Is there anyone else that is residing in the home? _____

Individuals residing OUTSIDE the home:

Mother/Stepmother/Other:_____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Occupation:_____ Employer: _____
Email address: _____ Years w/child: _____
Relationship with child: _____

Father/Stepfather/Other:_____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Occupation:_____ Employer: _____
Email address: _____ Years w/child: _____

Relationship with child: _____

Children/Siblings OUTSIDE the home:

How many children reside outside the home? *These include halfsiblings and stepsiblings*_____

Name Father Mother DOB Psych concerns?

Service Information

What type of services are you looking to receive? *Please select*

_____Individual Counseling
_____Family Counseling
_____Relationship/Couples Therapy
_____Co-Parenting
_____ Academic/Achievement Testing
_____ Autism/Developmental Evaluation
_____ Psychological Evaluation
_____ Neuropsychological Testing

What is your reason for seeking services?

Has the child seen a psychologist or mental health specialist in the past? If so, please provide information regarding when and who _____

What was the reason for seeking counseling at that time? _____

Health Information

Name of pediatrician: _____ Phone: _____

Address: _____

City State Zip

Current medical conditions: _____

Previous medical conditions: _____

Operations? _____

Hospitalizations? _____

Head injury/Broken bones? _____

Glasses? _____ Seizures? _____

Hearing? _____ Vision _____

Current Medications

Name	Dosage	Freq.	Reason	Prescribed by	Helpful?

Sleeping / Eating

Any problems with sleeping? _____

Any problems with eating? _____

Psychological/Psychiatric History

Ever hospitalized?_____

When	Where	How Long was the stay?	Reason

Outpatient follow-up?

Helpful?

Previous Diagnoses?

Substance Abuse History

Any history of substance abuse? Alcohol Abuse?

Substance/Drug 1st use Age of regular use Freq. Last use? Problems

Use tobacco products? Packs /day

Drink soda/coffee? Cans/cups per day

Educational History

Elementary School

What kind of grades? Ever failed or repeat?

Special Education/Learning Support?

Behavioral Problems?

Junior High School/Middle School

What kind of grades? Ever failed or repeat?

Special Education/Learning Support?

Behavioral Problems?

Senior High School/High School

What kind of grades? Ever failed or repeat?

Special Education/Learning Support?

Behavioral Problems?

Legal History

Ever arrested?

When For what Convicted? Sentence? Time Served Probation

What brings you into therapy?