Let's Talk
Therapy and Supervision

CHILD/ADOLESCENT INTAKE INFORMATION FORM

Today's Date: _____

DEMOGRAPHIC INFORMATION:

Name of Child: _____ DOB: _____

Age: _____

Person Completing Form: _____

Relationship to child: _____

Parents (Name and DOB):

Father: _____

Mother: _____

Home Address/Telephone of Mother:

_____

_____

Home Address/Telephone of Father:

_____

_____

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If parents share custody/visitation, describe the plan:

_____

_____

Name(s) of stepparents:

_____

Siblings (Names and Ages)

_____

_____

_____

PRESENTING CONCERNS:

What brings you to this appointment today for your child:

_____

_____

_____

_____

_____

How long have you been concerned about this:

_____

Describe times when concerns have been better:

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_____

_____

Describe times when concerns have been worse:

_____

_____

_____

Has your child been involved in treatment/therapy before for these or other concerns:
(circle) YES NO

If Yes: Name of Provider:

_____

When? _____

Length of Treatment? _____

How helpful was this experience?

_____

_____

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List any significant events/stressors consider may contribute to current concerns:

_____

_____

_____

MEDICAL HISTORY:

Name of Primary Care Physician/Pediatrician:

_____

Address:

_____

_____

List any medical conditions, illnesses, serious injuries, seizures, head trauma, surgeries, hospitalizations your child has experienced:

_____

_____

_____

List any food, drug, or environmental allergies your child has:

_____

_____

_____

Current medications prescribed to your child:

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Name of Medication	Dosage	Reason	Start Date	Prescriber

List any past medications your child has been prescribed:

_____

_____

_____

Any family history of medical/mental problems? (Mark with M-mother's side, F-father's side, B-both)

___Heart Disease ___High Blood Pressure ___Diabetes ___Cancer

___Lung Disease ___Stroke ___Dementia ___Anxiety ___Depression

___Bipolar Disorder ___Schizophrenia

___ADHD ___Legal Problems ___Psychiatric Hospitalizations

___Other_____

Describe your child's activity level: (circle):

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Active Energetic Sluggish Underactive

Describe your child's appetite: (circle):

Healthy Picky Excessive Poor

Describe your child's sleep pattern: (circle):

Normal Difficult to fall asleep

Awakens in the night Restless Difficult to awaken in the morning

Any history of: (circle): Night terrors Nightmares

Sleep walking Sleep talking

DEVELOPMENTAL HISTORY:

Describe pregnancy with your child:

_____

_____

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Describe delivery (any complications?):

_____

_____

How did your child meet developmental milestones?

(Rate as: N-normal, E-early, L-late):

Sitting Up_____ Crawling_____ Standing Up _____

Walking_____ Talking_____ Toilet training_____

Describe any concerns regarding your child's development:

_____

_____

_____

Describe your child's temperament as an infant: (circle those that apply):

Active Alert Calm Easy to Soothe Difficult to Soothe

Slow to Warm up Colicky/Fussy Cuddler Tense

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Reactive to Touch Poor Eye Contact Withdrawn Separation Anxiety

EDUCATION:

Name of School your child attends: _____

Location_____

Grade: _____

Teacher: _____Counselor: _____

Has your child had testing done through the school: Yes No

If yes, did child qualify for specialized services through an

IEP? Yes No **504 Plan**: Yes No

Specialized services for:

_____

_____

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List any concerns/difficulties with your child and school:

_____

_____

_____

ADDITIONAL INFORMATION: Please share any additional information you consider is important for me to know:

_____

_____

_____

_____

_____

_____

_____

THANK YOU!

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