Child and Adolescent Intake Form

To be filled out by the parent or guardian requesting services for the minor child. This information will help your child's life coach understand your child. This along with all other information will remain confidential.

BACKGROUND INFROMATION

Child's Name_____ DOB____/____/____ AGE _____

Child Lives With (Check One): Both biological parents ___Mother _____ Father ____Other_____

If parents are divorced, describe custody arrangements: _____

_____

Child's Address: _____

Emergency Contact Person (other than parent): _____

Phone Number _____

Custodial Parent's Contact Information:

Home # _____ Cell_____ Work _____

Email Address: _____

Circle the Best Way to Contact you for Appointment Reminders: Cell Text Work Email

INFORMATION ABOUT CHILD'S MOTHER

Mother's Name _____ Age _____ Race _____

Employer _____ Occupation _____

Hrs/Wk _____ Can you be contacted at work? Yes or No

Circle the Best Way to Contact you: Home Cell Work Email

Email: _____

Denomination _____ Church (if applicable) _____

Describe any problems that you have which require physical or medical care: _____

_____

Are you currently receiving medical treatment? Yes No

Medication(s) currently using? _____

Previous Counseling/Therapy? Yes No If Yes Please Explain _____

_____

INFORMATION ABOUT THE CHILD'S FATHER

Father's Name _____ Age _____ Race _____

Employer _____ Occupation _____

Hrs/Wk _____ Can you be contacted at work? Yes or No

Circle the Best Way to Contact you: Home Cell Work Email

Email: _____

Denomination _____ Church (if applicable) _____

Describe any problems that you have which require physical or medical care: _____

_____

Are you currently receiving medical treatment? Yes No

Medication(s) currently using? _____

Previous Counseling/Therapy? Yes No If Yes Please Explain _____

_____

FAMILY MEMBERS

List all people currently living in the home, their age, and how they are related to the child: _____

_____

_____

_____

_____

Describe the Issue(s): _____

_____

_____

_____

_____

Check All Problem Areas:

_____ Anger

_____ Depression

_____ Suicidal Ideations

_____ Suicidal Attempts

_____ Rape/Incest Victim

_____ Problems with Social Relationships

_____ Negative Peer Influences

_____ Low Self-Esteem/Low Self-Worth

_____ Promiscuity

_____ Sexual Concerns

_____ Drugs/Alcohol Issues

_____ Negative School Behaviors

_____ Physical Aggression

_____ Religious/Spiritual Concerns

_____ Other (Please Describe): _____

_____

CHILD'S MEDICAL HISTORY

List child's sickness, operations, and injuries. Please indicate the age and the severity of it. Indicate also if there were a difficult delivery/pregnancy or any head trauma to the child. _____

_____

_____

Have there been any psychological, psychiatric, neurological, or EEG evaluations: Yes No

If so, please list names and dates of contact. _____

Describe previous speech and hearing therapy (if any) _____

What is the date of your child's last physical exam? _____

Physician's Name: _____

ACADEMIC/SCHOOL INFORMATION

School Name _____ Grade___ Teacher (if applicable) _____

_____

Has your child ever been kicked out of school? Yes No If so why? _____

_____

How does your child get along with peers at school? _____

_____

How does your child get along with school staff? _____

_____

Describe any difficulties with learning: _____

_____

Describe what your child likes to do for fun (special interests, hobbies): _____

_____

_____

_____