



## **CHILD/ADOLESCENT INTAKE**

**Please provide the following information about your Child/Adolescent:**

Child/Adolescent's Full Name:

Nick Name:

Birth Date:

Today's Date:

**Behavioral Excesses:**

What does your Child/Adolescent currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

**Behavioral Deficits:**

What does your Child/Adolescent fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

**Behavioral Assets:**

What does your Child/Adolescent do that you like? What does he /she do that other people like?

**Others Concerns:** Do you have any other concerns about your Child/Adolescent or your family that you have not mentioned yet.

**Treatment Goals:** From your preceding list of your Child/Adolescent's behavior and your family concerns, what problem behaviors do you want to see change FIRST?

**Please provide the following information about your Child/Adolescent:**

**Family History:**

The name of the Child/Adolescent's biological parents:

Mother:

Father:

Who does your Child/Adolescent currently live with?

Does anyone in the Child/Adolescent's family use currently (or in the past) any type of drug,tobacco, or alcohol?

If yes, Please describe:

**Educational History:**

What school does your Child/Adolescent attend?

Current Grade or year:

What does your Child/Adolescent's teacher say about him/her?

Other schools attended (including Pre-school), by year

Has your Child/Adolescent ever repeated a grade? If so which one(s)

Has your Child/Adolescent ever received special education services?

Has your Child/Adolescent experienced any of the following problems at School (Circle):

- \* fighting \* lack of friends \* drug/alcohol \* detention
- \* Suspension \* learning disabilities \* poor attendance \* poor grades
- \* gang influence \* incomplete homework \* behavior problems

**Medical History:**

What is the name of your Child/Adolescent's medical doctor?

Did the Child/Adolescent's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy?

If so, please list which ones

Did the Child/Adolescent's mother have any problems during the pregnancy, or at delivery? If so, Please describe them:

Has your Child/Adolescent experienced any of the following medical problems (Circle)?

- \* A serious accident \* Hospitalization \* Surgery \* Asthma
- \* A head injury \* High fever \* Convulsions/seizures
- \* Eye/ear problems \* Meningitis \* Hearing problems
- \* Allergies \* Loss of consciousness

\* Other

Please list any current medical problems or physical handicaps:

Please list any medications your Child/Adolescent takes on a regular basis:

**Other History:**

Has your Child/Adolescent ever experienced any type of abuse (physical, sexual, or verbal)? If so please describe:

Has your Child/Adolescent ever made statements of wanting to hurt him/her self or seriously hurt someone else? Has he/she ever purposely hurt himself or another?

Has your Child/Adolescent ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your Child/Adolescent and his/her family?