Child/Adolescent Intake Form

Name of child/adolescent: _____ Date of Birth: _____
Place of Birth: _____
Current Address where child/adolescent is residing: _____
_____

Preferred phone number(s) for primary guardian: _____
Is it okay to leave a voicemail at this number? YES NO
Preferred email for primary guardian: _____
Is it okay to correspond via email? YES NO

Is this child/adolescent in DSS custody: YES NO.
What is the contact information of the DSS caseworker?
_____

Please give a brief description of why this individual is seeking treatment:

_____
_____
_____
_____
_____

1. Parent or Guardian's Name:
   Relationship to Child: _____
   _____
   Does this individual have full or partial custody: _____

2. Parent or Guardian's Name:
   Relationship to Child: _____
   _____
   Does this individual have full or partial custody: _____

Describe any known family history of mental health or substance abuse issues (please include grandparents, aunts, uncles, siblings, parents, etc.)

_____
_____
_____

Academic History

Name of School:	Grades Attended:	IEP, 504 or Inclusion Classes?	Suspensions or Expulsions?
Name of School:	Grades Attended:	IEP, 504 of Inclusion Classes?	Suspensions or Expulsions?

Medical History

Name of Primary Care Doctor:	Address of provider:	Phone #: Fax #:
Name of Psychiatrist (if applicable):	Address of provider:	Phone #: Fax #:

List any known allergies (medication or otherwise):

_____

_____

List any medical issues (current or past) as well as any medications prescribed (including dosages):

_____

_____

_____

_____

Developmental History of Child/Adolescent

Were there any problems during pregnancy? If so, please describe.	
Were there any problems during delivery? If so, please describe.	
Were there any problems with this child reaching development milestones (speech, vision, hearing, walking, toilet training, etc..). If so, please describe.	

Previous Mental Health History

Provider/Agency name:	Reason for treatment:	Length of treatment:
Provider/Agency name and address:	Reason for treatment:	Length of treatment:
Provider/Agency name and address:	Reason for treatment:	Length of treatment:

Signature: _____ Date: _____