



**CHILD/ADOLESCENT
INTAKE ASSESSMENT**

Date _____

Child's name _____ M F Social Security # _____
Address _____ DOB _____
City _____ State _____ Zip Code _____ Phone _____
Parent(s)/Guardian(s) _____
Email Address _____ Alternate Phone _____
Emergency contact _____ Relationship _____ Phone _____
Who lives in the home at the current time? (name, age, relationship) _____

Reason for seeking counseling _____

Has the child had previous counseling? Yes No Only as part of family
Where _____ When _____
Was it helpful? _____

Has the child had previous substance abuse treatment? Yes No Only as part of family
Where _____ When _____
Was it helpful? _____

EDUCATIONAL HISTORY

School _____ Grade _____ Teacher _____
School Counselor/Social Worker _____
Has the child ever been diagnosed? Learning Disability ADHD Sensory Integrative Autism
 Oppositional Defiant Emotionally Impaired Pervasive Developmental Dis. Physical Impairment
Describe the child's academic performance: _____

Does the child struggle with distractibility? Yes No School thinks so, I'm not sure Sometimes
Has the child struggled with any of the following? Truancy Suspension Fighting Vandalism
 Expulsion Defiance School refusal Threatening behaviors Weapons Separated from parent
What does the child do well at school? _____
Has the child ever been held back? No Yes, when? _____

LEGAL SYSTEM INVOLVEMENT

Has the child been involved with the legal system? Yes, in the past Currently No
If so, please explain _____

Is the child on probation? No Yes, probation officer _____

FAMILY HISTORY

Does anyone in the extended family unit have a history of alcoholism? No Yes, please explain _____

Drug abuse? No Yes, please explain _____

Depression? No Yes, please explain _____

Anxiety? No Yes, please explain _____

Mental Illness? No Yes, please explain _____

Other Addictions? No Yes, please explain _____

Has the child ever been abused? No Yes, Physical Emotional Sexual Spiritual Verbal
explain _____

HEALTH HISTORY

Where was the child born? _____ Adopted? No Yes, at age _____

Explain any complications the mother had during pregnancy or labor _____

Child's physician/pediatrician _____

Is the child being treated for a medical condition? _____

Please list hospitalizations _____

Please list current medications _____

Please list current allergies _____

Has the child ever had a seizure? No Yes, specify _____

Has the child ever had a head injury? No Yes, specify _____

Does the child complain of frequent headaches? No Yes, specify _____

Does the child complain of dizziness? No Yes, specify _____

Does the child have current difficulties with wetting/soiling? No Yes, specify _____

Does the child have adequate personal hygiene habits? No Yes

At what age did the child walk _____ talk _____ complete toilet training _____

Eating Habits? No Change Not Eating Over-Eating Significant Weight Change _____ lbs.

Selective Eating Habits _____ Other _____

Sleeping Habits? No Change Trouble Getting To Sleep Trouble Staying Asleep Early Waking

Sleepwalking Nightmares/terrors Other _____

HARMFUL BEHAVIORS

Are you concerned about suicidal statements or gestures with the child? No Yes, explain _____

_____ Prior Attempt, explain _____

Are you concerned about the child seriously injuring others? No Yes, explain _____

_____ Prior Attempt, explain _____

Other risk/safety factors _____

PERSONALITY

Does the child form friendships easily? Yes No Only in small crowds
Does the child struggle with any of the following? "Late Bloomer" Bullying Easy Target
 Extremely Shy Needs Social Reassurance Other _____

Who is the child's best friend at the current time? _____

What does the child do well socially? _____

What are some of the child's favorite activities/toys? _____

Is the child a part of any groups/organizations? No Yes
If yes, what? _____

Cultural Heritage _____

SPIRITUALITY

Is your family affiliated with a church? No Yes, where? _____
Who is the minister/reverend? _____

How often do you attend? Regularly Sporadically Holidays Never

Is the child involved in a church youth group? No Yes Sometimes

PREPARATION FOR COUNSELING

Have you spoken with the child about why he/she is coming to counseling? No Yes
What is the last major change in the child's life? _____

Has the child ever experienced a traumatic event? No Yes, explain _____

Is there anything else that the therapist should know about the child? _____

Is there anyone else who should be invited into the counseling process with the child? No Yes,
Whom _____

Comments _____

TREATMENT PLANNING

What would you like to see occur from counseling services for the child? _____

How frequently would you like the child's counseling sessions to be scheduled?

- as needed 1x/month 2x/month 3x/month 4x/month don't know yet

Is everyone in the child's family aware of the concerns? Yes No

Is everyone in the family willing to participate in counseling? Yes No Don't know

Is there anything else the child's counselor should know? _____

My signature below indicates that I have completed this intake form with accurate data and I give Desert Streams Christian Counseling Services consent to render professional counseling services for the child that is indicated on this form.

Signature _____ Date _____