CHILD & ADOLESCENT DEVELOPMENTAL HISTORY INTAKE FORM

Date:

Child's Name:
_______________________________________ D.O.B.: _____________ Age:____
School:
_________________________ Teacher:__________________ Grade: ___________
How does your child do in school academically?
____
How does your child do in school behaviorally?
____
Does your child have a learning or physical disability? __Y, __N, __Maybe.
Specify:
____
Does your child have a mental health diagnosis? __Y, __N, __Maybe
Specify: ____

Does your family have specific spiritual/religious beliefs?
____

Child's residence
: ___Biological parent's home ___ Relative's home ____Biological and step parent's home ___Foster Home ___ Adoptive Home
Parent's status
: ___single, never married ___ married, when? ___ ___ separated, when ? ___
___ divorced , when ? ___ ___ live-in partner, how long ? ___
___ widow , when ? ___

CUSTODIAL PARENT HOME ADDRESS:

____

City:___________________ State: ___________ Zip:____________

E-MAIL: ____

Phone: H: ___________________W: _______________Cell:____________________

Best number to reach you ___H ___W ___Cell ___other_______________________

Occupation: __________________________ Length of time at this position _______

NON-CUSTODIAL PARENT HOME ADDRESS (if applicable):
____

City:____________________________ State: ________________ Zip:_____________

E-MAIL: ____

Phone: H: ____________________W: __________________Cell:__________________

Best number to reach you ___H ___W ___Cell ___other_________________________

Occupation: ____________________________ Length oftime at this position ________

If separated or divorced, visitation schedule:
____

Any Involvement with Child Protective Services? ___ Y ___ N

Describe:__________________________________

People in household: Siblings (list names and ages______________________________

Others (list name and relation to child)
____ ______________________________

How many times has the child moved homes? __________________________________

Does either parent have current legal involvement? If yes, explain:
____

MEDICAL HISTORY
Primary Care Physician: ____

Phone:____

Last seen on: _________________ Reason for last visit:___________________________

Current medications: (Include dosage and frequency)____________________________

____

Allergies:
____

List any birth complications (Ex: Premature, jaundice, C-section, etc.__________

____

During pregnancy, did mother use:
_______ Cigarettes, ____ Alcohol, ____ Drugs, ____ Experience Extreme Stress?

Specify frequency, amounts, and duration:
____ __________________________________

____

Milestones, what age did your child start to: Sit-up: _________ Crawl: _________

Walk: _________ Talk: _________ Toilet trained: _________

Reached developmental milestones: __On time, __Early, __Late

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)___

____

____

Does child use: ____ Cigarettes, ___ Alcohol, ____ Drugs

Specify amount and frequency:
____

Do you feel your child has a problem with drugs or alcohol? ________ Yes ______No

Has the child been in counseling before: ______Y ______N, Age (s):_________

Name of prior therapist and reason for treatment:____________________________

____

May I contact them? ____Y ____ N Phone __________________________________

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):
____

____

Has your child witnessed: domestic violence? ____Y, ____N,

Has your child ever experienced: verbal abuse? ___, __N, physical abuse? __Y, __N

sexual abuse? __Y, __N, __Suspected. Specify________________________________

____

Other stressors or traumas? ____

____

Responsible Party for insurance ____

Company: _____________________________Policy #_________________________

Referral source: ____

PERSONAL HISTORY

How does your child handle anger or change? _______________________________

____

Has the child experienced any significant loss? If yes, explain:

____

____

What do you view as your child's major strengths and positive traits?

____

What are your child's hobbies/interests? __________________________________

____

Briefly describe your goals for your child's therapy:

_____________________________ ______________________________________

____

What are three adjectives that describe:

Mother:

____

Father:

____

Step parent: ____

Child:____
Parental Relationship:

____

Check any symptoms your child displays: ___ Anger _
__ Anxiety ___ Bed wetting ___ Acts out sexually
___ Conduct problems ___ Controlling Day defecation ___ Running Away ___ Shy
___ Has unusual sexual knowledge ___ Plays out sexual themes ___ Peer problems
___ Day wedding ___ Defiance ___ Depression ___ Homicidal thoughts or actions
___ Drug or alcohol use ___ Hyperactivity ___ Masturbates excessively
___ Hyper vigilance ___ Isolation ___Lack of empathy ___Lack of motivation
___ Lethargy ___Low impulse control ___ Plays out violent themes ___ Sleeplessness
___ Low self-esteem ___ Lying ___ Nightmares ___Over/Under eating ___ Phobias
___ Stealing ___ Tantrums ___ Somatic Symptoms(Headaches/Stomachaches, etc).

Other: ____
How is your child disciplined? Please list each method and frequency of use:
____

____

____
What goals would you like your child to work on in therapy?

____

____
Please list any information you deem to be important for the therapist to know:

____

____ ___

____

____

THIS FORM COMPLETED BY: ________________________________Date________