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Biographical Information – Child/Adolescent Intake Form

Name:_____ Current Date:_____

Parent's Names:_____ Birth Date:_____

_____ Age:_____

Current Address:_____ School:_____

_____ Grade:_____

Home Phone:_____ Physician:_____

Cell Phone:_____ Insurance:_____

Parent's Employment: _____ _____

_____ Source of Referral:_____

_____ _____

SIBLINGS: Name Age Comments

1._____

2._____

3._____

4._____

5._____

List Names and Addresses of any Other Professionals Consulted:

1._____

2._____

3._____

Reason for coming to psychotherapy? Give a brief summary of main problems:_____

_____

_____

When did you first notice a problem?_____

_____

PREGNANCY HISTORY:

Age of Mom at conception:_____ Desired sex of child: _____ Pregnancy planned or unexpected? _____Previous perinatal loss:_____

Describe any physical complications or symptoms during pregnancy:_____

_____

Describe any family events or changes occurring within one year before or after the birth:

_____

Give a brief biography of child's birth:_____

_____

_____

INFANCY-TODDLER HISTORY:

Was your child beast fed?_____ Until what age?_____

Give a brief description of child's first three years: _____

_____

_____

In these developmental milestones was your child slow, on task or above average?

Walking:_____ Talking:_____

List any additional significant events of childhood: _____

_____

_____

_____

Were any of the following present to a significant degree during the child's first year's of life?

Was not calmed by being held or stroked?_____

Did not enjoy cuddling?_____

Colic:_____ Excessive restlessness?_____

Sleeplessness due to restlessness or easy arousal?:_____

Frequent head banging?_____

Constantly into everything?_____

Excessive number of accidents compared to other children?_____

_____

TEMPERAMENT:

Describe the child's body function regularity in sleep, hunger, bowel movements:_____

_____

Adaptability to change in routine and the ease or difficulty in modifying child's initial response:

_____

Response to new situations, new food, people, places, toys, etc.:_____

_____

Mood - amount of pleasant and unpleasant behavior throughout a day:_____

_____

Distractibility - degree sounds, people, etc., interfere with child's ongoing activity:_____

_____

Persistence - duration of activities:_____

How would you rate your child's overall level of intelligence compared to other children?

Below Average:_____ Average:_____ Above Average:_____

SCHOOL:

Academic learning ratings: Good Average Poor

Day Care:_____

Nursery school:_____

Kindergarten:_____

Current grade:_____

What grade level is your child currently functioning in the following subjects?

Reading:_____ Spelling: ____ Math: _____Writing: _____ Science: ____ History: _____

Has the child repeated a grade?_____ If so when?_____

Present class grade placement:_____ Regular or special class?_____

School:_____ Teacher:_____

Describe kinds of special assistance your child is currently receiving:_____

_____

Describe briefly any academic school problems:_____

_____

Has your child had special testing?_____

IF SO, PLEASE INCLUDE OR SEND A COPY OF THE REPORT.

SCHOOL:

Rate child's behavior in school settings: Good Average Poor

Nursery school:_____

Kindergarten:_____

Current grade:_____

Does the teacher describe any of the following as significant classroom problems?

_____ Does not sit still in seat _____ Frequently gets up and walks around the class

_____ Shouts out without being called on _____ Won't wait for their turn

_____ Fiddles at their desk _____ Does not do homework

_____ Does not cooperate well in groups _____ Better in a one-to-one relationship

_____ Does not respect the rights of others _____ Difficulty paying attention

Briefly describe additional behavior problems in the classroom:_____

_____

_____

What does the teacher consider to be your child's strengths:_____

_____

_____

_____

PEER RELATIONSHIPS:

Seeks friendships with peers?_____ Sought by peers?_____

Mostly friends with others their own age?_____ Younger?_____ Older?_____

Describe any problems your child is having with peers:_____

_____

_____

Do you consider your child in social settings to be more a leader or follower?_____

_____

MEDICAL HISTORY: (Include age and any complications)

Childhood diseases:_____

_____

Allergies:_____

Surgical Operations:_____

MEDICAL HISTORY: (Include age and any complications)

Hospitalizations other than operations:_____

_____

Head Injuries:_____

Convulsions:_____

_____ with fever_____ without fever_____

Coma:_____ Meningitis, encephalitis:_____

Persistent high fevers:_____ Highest fever recorded:_____

Eye Problems:_____ Ear problems:_____

Poisoning:_____

Abuse (physical and/or sexual):_____

PRESENT MEDICAL STATUS:

Height:_____ Weight:_____Medications now taking on a regular basis:

_____

Present illness(es): _____

_____

Is child responsible for their own hygiene?_____

FAMILY HISTORY OF MOTHER:

Mother's age today:_____ Number of previous pregnancies:_____

Number of spontaneous abortions:_____ Number of induced abortions:_____

Infertility problems:_____

Mother's school experience: Learning Problems:_____

Behavior Problems:_____

Medical Problems:_____

Have any blood relatives had any problems similar to those your child experiences?_____

_____

_____

Were your parents physically or sexually abused?_____

_____

Do you or other members of your family or your parents have a history of drug and/or alcohol use or abuse?_____

FAMILY HISTORY OF FATHER:

Father's age today:_____ Age at child's birth:_____Infertility Problems:_____

Father's school experience: Learning Problems:_____

Behavior Problems:_____

Medical Problems:_____

Have any blood relatives had any problems similar to those your child experiences?_____

_____

_____

Were your parents physically or sexually abused?_____

_____

Do you or other members of your family or your parents have a history of drug and/or alcohol use or abuse?_____

_____

What are your family's values about nudity in the home?_____

_____

What are the sleeping arrangements in the home?_____

_____

What are the words your child uses for private parts of their body and urination and defecation?

_____

CHILD INFORMATION:

Child's identified fears:_____

_____

_____

Child's weaknesses and strengths:_____

_____

_____

What responsibilities does your child have at home and how do they carry them out? ____

_____

How do you discipline your child?_____

_____

CHILD INFORMATION:

Do you ever criticize your child?_____

How? _____

Over what issues?_____

What are your major concerns about your child?_____

_____

_____

What have you attempted to do about this concern?_____

_____

What do you hope to see accomplished by your child receiving psychotherapy?_____

_____

_____

What are you committed to in your life at this time?_____

_____

_____

Please describe a typical day, including family rules, schedule, problem areas, time for communication (use back of sheet if needed):_____

_____

_____

_____

TRAUMATIC EVENTS:

Has your child experienced any major changes, losses or trauma in the past year such as death, hospitalization, deformity or sickness of a family member or friend; divorce or remarriage of parents; birth of a sibling; parent starting or stopping work; start of a change in school or childcare; family members entering or leaving home on a permanent basis; change in family's financial status; witness to or victim of abuse of any kind; involved in drugs or alcohol; suspension from or failure in school; loss or robbed of important possession; change in where he/she lives or any other factor you feel is relevant to the life of your child?

_____

_____

_____

_____

_____