Path to Awareness
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CHILD/ADOLESCENT INTAKE FORM

Client's NAME _____ DATE OF BIRTH_____

ADDRESS _____

ZIP _____ PHONE (____) _____

Person filling out this form _____ Relationship to Client _____

Contact Information:

Name of Biological Mother_____

Phone: (___)_____ (____)_____

Address:_____

Occupation _____Work Phone (___)_____

Name of Biological Father_____

Phone: (___)_____ (____)_____

Address:_____

Occupation _____Work Phone (___)_____

Name of Guardian \ Parent with whom child is living if not Biological Parent _____

Phone: (___)_____ (____)_____

Address:_____

Occupation _____Work Phone (___)_____

Name of Guardian \ Parent with whom child is living if not Biological Parent_____

Phone: (___)_____ (____)_____

Address:_____

Occupation _____Work Phone (___)_____

In case of emergency who are we to contact regarding your child?
Name: _____ Relationship to Child_____

Phone: (___)_____ (____)_____
Please list the names of all persons who live in the home with the child:

Name Age Relationship to child

_____

_____

_____

_____

Does your family currently have a case open with Services for Children and Families? Yes _____ No _____

If so, what is the caseworker's name? _____ Phone _____

Who has legal Custody? _____

CURRENT HEALTH CARE PROVIDERS

Primary Care: Name _____ Office Phone _____FAX_____

Address_____

Most recent appointment_____

Psychiatrist or other specialist: Name _____

Office phone_____ FAX_____

Address_____

Most recent appointment_____

Psychologist or Therapist Name: _____ Office Phone _____FAX_____

Address_____

Most recent appointment_____

Reason for Evaluation:

_____
_____
_____
_____
_____
_____
_____

PREGNANCY

Length of Pregnancy_____ Moms' Health Problems during pregnancy:

_____

_____

Did mom have prenatal care? _____

Moms' Drug, Alcohol and or Medications Used (type, amount, trimester of pregnancy):

_____

Mom exposed to trauma \ severe stress during pregnancy?

_____

_____

DELIVERY

Complications?_____

Forceps or Vacuum Extraction? ___yes ____ no Cesarean _____ yes _____ no

Birth Weight _____ Apgar scores _____one minute _____ five minutes _____ (don't know _____)

Days in Hospital? _____

DEVELOPMENTAL MILESTONES

When did your child perform the following?

Sitting by self	7-9 mos. _____	10mos.-1yr _____	other _____	
Walking	1-10 mos. _____	11-14 mos. _____	other _____	
¾ word sentences	1-2 yrs. _____	3-4 yrs. _____	5 yrs. _____	
Toilet training	1-2 yrs. _____	3-4 yrs. _____	5 yrs. _____	Not yet_____

Off breast at _____mos. Off bottle at _____ mos.

MEDICAL HISTORY

Has your child ever experienced any of the following? (PLEASE EXPLAIN)

HOSPITALIZATION

_____

_____

_____

SURGERY

_____

_____

SERIOUS INJURIES (include Head injuries)

_____

_____

CHILDS GENERAL HEALTH

Has your child had ongoing problems with:		Describe
Skin trouble	Yes_____	_____
Frequent ear infections	Yes_____	_____
Strep throat infections	Yes_____	_____
Eye problems	Yes_____	_____
Vomiting	Yes_____	_____
Diarrhea	Yes_____	_____
Headaches	Yes_____	_____
Seizures	Yes_____	_____
Kidney/bladder infections	Yes_____	_____
Joint problems	Yes_____	_____
Heart problems	Yes_____	_____
Chronic cough/wheeze	Yes_____	_____
Asthma	Yes_____	_____
Wets clothes while awake	Yes_____	_____
Wets while asleep	Yes_____	_____
Bowel movements in clothes	Yes_____	_____
Other conditions	Yes_____	_____

Does your child wear glasses? Yes _____

Is your child Allergic to any medication? Yes____Please list medication and type of reaction

_____

_____

What medications is your child on at the present time?

MEDICATION	DOSES AND TIMES	PRESCRIBER (MD, PNP, PA NAME)

Medications tried in the past?

MEDICATION	WHY WAS IT STOPPED?

PARENTING

1. What do you do for/or with your child that is enjoyable?

_____

_____

_____

2. What parenting techniques do you use?

Technique	Yes	Explain

Time outs		
Spanking		
Removal of privileges		
Isolation		
Rewards		
Send to room		
Stand in corner		
Early bedtime		
Withhold food		
Other_____		
Other_____		

FAMILY HEALTH HISTORY

Please indicate if any family member (other than child) has had the following problems:

	Birth Mother		Birth father		Biological brother		Biological sister		Biological grandparents	
	Yes		**Yes**		**Yes**		**Yes**		**Yes**	
Depression										
Mania (Bipolar)										
Psychosis (Schizophrenia)										
Anxiety										
Panic Attacks										
Obsessive Compulsive										
Tics or Tourette's										
Alcoholism										
Drug Dependence										
Been Abused										
Asperger \ Autism										
Sleep Apnea										
Seizures										
Asthma										
Bowel Disease										
Skin Disease										
Heart Disease										
Diabetes										
Obesity										
Criminal Conviction										
Psychiatric Hospital Stay										
Inpatient Drug and Alcohol										
Other Psychiatric Condition (list below)										
Other Medical Condition (list below)										

_____

Have any members of your family died? If so, please list cause of death and the age they were when they died.

_____ _____

_____ _____

CHILD BEHAVIOR INFORMATION

Check below which applies to your child's behavior.

Behavior	Check	Explain
Aggressiveness (physical)		
Aggressiveness (verbal)		
Hyperactive Anxiety	_____	_____
Attempts to hurt self or talks about		
Cheating		
Depression		
Fears		
Fire setting		
Lying		
Negative attitude about others		
Negative attitude about self		
Defiant		
Poor hygiene		
Poor peer relationships		
Poor sibling relationships		
Sexual acting-out		
Stealing/shoplifting		
Suicidal statements, attempts, or gestures		
Repetitive Behaviors		
Tantrums		
Other _____		
Other_____		

List below your child's strengths:

_____

_____

_____

_____

What kind of play, daily activities, and hobbies does your child engage in?

_____

_____

CARETAKER INFORMATION

1. Preschool child care adjustment: No Difficulties_____ Difficulties_____ Please describe:

_____

2. Who took care of your child prior to going to school? _____
3. Has your child ever lived out of the home? Yes_____ No_____

Please list placements and dates: _____

_____

_____

4. Who is currently involved in taking care of your child? _____
   How often, and what times of the day or evening? _____
   Are there any problems during these times? Please describe briefly:

   _____

   _____

COMMUNITY/NEIGHBORHOOD STRESSORS

We would like to know whether any of the following neighborhood or community conditions are a serious problem for your child or your family (check all that are now or recently were a problem).

_____Poor job opportunities	_____Poor police protection	_____Inadequate legal help
_____Poor or no job training	_____Unfair credit practices	_____Discrimination
_____Poor schools	_____No day care centers for children	_____Unsafe neighborhood
_____Poor recreational opportunities	_____Rundown neighborhood	_____Heavy drug use in area
_____No home care svc for aged/sick	_____Fears about immigration	_____Gang problems

_____Other (specify)_____

_____No community or neighborhood situations are a serious problem for child or family

STRESSORS FOR FAMILY

1. Has your family faced any special problems during the last year such as separation or divorce, illness or injury, loss or change of job or income, death, emotional difficulties, etc.? Explain briefly.

_____

_____

2. Is anyone in your family currently experiencing (or has experienced within the past year) moderate or serious financial stressors? Please explain.

_____

_____

3. Is anyone in your family currently experiencing (or has experienced within the past year) moderate or serious legal stressors? For example, involving court, probation, police, attorneys, etc. Please explain.

_____

_____

HOUSING CIRCUMSTANCES

1. Number of adults living in household _____ Number of children living in household _____
2. Type of household: (check one)
   _____Apartment Number of bedrooms _____
   _____House Number of bedrooms _____

CULTURAL BACKGROUND/ETHNICITY

1. How does your child think of him or herself as far as ethnicity is concerned? (If your child does not identify him or herself as a particular ethnicity, please state this.)

_____

2. Has your child been raised for a significant period of time in another country or culture? What ages? Where?

_____

3. What is the culture/ethnicity of each parent? Mother_____ Father_____

ADDITIONAL INFORMATION

Please list any additional information you feel would be helpful.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for completing this form!