HEADWATERS COUNSELING

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headwaterscounseling.net

CHILD/ADOLESCENT INTAKE FORM (AGE 17 OR UNDER)

Dear Parent/Guardian: To help your clinician better understand and help your child/adolescent, please answer the questions on this form and bring it with you to his/her first appointment.

Child/Adolescent's Legal Name:_____**Date of Birth:** _____

Forms completed by: _____ **Relationship**: _____

Is the child/adolescent adopted? ◯ Yes ◯ No

Describe their best characteristics:

Gender Identity *(optional):* ◯ Male ◯ Female ◯ Transgender ◯ Cisgender ◯ Non-binary

Sexual Identity *(optional)*: ◯ Heterosexual ◯ Gay ◯ Lesbian ◯ Bisexual ◯ Pansexual ◯ Undecided

Race/Ethnicity *Please check all that apply (optional)*:

☐ African American ☐ Arab American ☐ Asian or Pacific Islander ☐ Caucasian

☐ Hispanic ☐ Multi-racial ☐ Native American ☐ Other:_____

What is the primary reason for having your child/adolescent come in for counseling?

DSM-5 PARENT/GUARDIAN
RATED LEVEL 1 CROSS-CUTTING SYMPTOM MEASURE – CHILD/ADOLESCENT

None: Not at all **Slight**: Rare, less than a day or two **Mild**: Several days **Moderate**: More than half the days **Severe**: Nearly every day

	During the past TWO (2) WEEKS, how much (or how often) has your child/adolescent...	None	Slight	Mild	Mod-erate	Severe	Highest Domain Score
I	1. Complained of stomach aches, headaches, or other aches and pains?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	2. Said he/she was worried about his/her health or about getting sick?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
II	3. Had problems sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
III	4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	5. Had less fun doing things than he/she used to?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
IV	6. Seemed sad or depressed for several hours?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	7. Seemed more irritated or easily annoyed than usual?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	8. Seemed angry or lost his/her temper?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
V	9. Started lots more projects than usual or did more risky things than usual?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	10. Slept less than usual for him/her, but still had lots of energy?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
VI	11. Said he/she felt nervous, anxious, or scared?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
VII	12. Not been able to stop worrying?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	13. Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
VIII	14. Said that he/she heard voices – when there was no one there – speaking about him/her or telling him/her what to do or saying bad things to him/her?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
IX	15. Said that he/she had a vision when he/she was completely awake – that is, saw something or someone that no one else could see?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
X	16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
XI	18. Seemed to worry a lot about things he/she touched being dirty or having germs or be poisoned?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
XII	19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	

In the past **TWO (2) WEEKS,** has your child/adolescent...							
XIII	20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	21. Smoked a cigarette, a cigar, or pipe, or using snuff, or chewing tobacco?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	22. Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	24. In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
	25. Has he/she EVER tried to kill himself/herself?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	

Are there other concerns (not listed above) that you want to discuss?

How have these concerns impacted your child/adolescent's daily life?

YOUR CHILD/ADOLESCENT'S FAMILY AND SUPPORTIVE RELATIONSHIPS

Are parents divorced or separated? ◯ Yes ◯ No

If yes, how long?

What are the current custody/visitation arrangements?

Please tell us about the household/family which your child/adolescent spends the majority of his/her time (or who currently lives with your child/adolescent). List primary household information first, and then list other living situations/supportive relationships:

Name	Age	Relationship (e.g. Spouse, Child, Friend, etc.)	Quality of Relationship	Living with you?
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No

YOUR CHILD/ADOLESCENT'S LIFE STORY

Where does your child/adolescent attend school?

What is the highest grade level of school he/she has completed?

What has been his/her usual report card grades?

What has been his/her most recent grades?

Has he/she experienced any of the following in school?

◯ Learning Problems ◯ Discipline Problems ◯ Social Problems ◯ Emotional Problems

Has there been any academic (IEP) or psychological testing done at school or elsewhere? ◯ Yes ◯ No

If yes, when?

Results:

Has your child/adolescent ever received previous counseling, therapy, or psychiatric treatment? ◯ Yes ◯ No

If yes, with whom?

Has your child/adolescent ever been the victim of abuse or neglect? ◯ Yes ◯ No

If yes, was the abuse: ◯ Physical ◯ Sexual ◯ Emotional ◯ Neglect ◯ Verbal

Please list any contacts your child/adolescent has had with the courts (including Friend of the Court):

Please list any contacts your child/adolescent has had with the police or Child Protective Services:

Has your child/adolescent ever had a problem with alcohol or other drugs? ◯ Yes ◯ No

Explain any "Yes" answers above:

What is your family's current religious affiliation?

Describe family involvement:

MEDICAL HISTORY

Does your child/adolescent have any current medical concerns?

Has he/she had any past surgical procedures? ◯ Yes ◯ No

If yes, list:

Has he/she been exposed to any contagious diseases such as Tuberculosis? ◯ Yes ◯ No

If yes, to what and when did the exposure take place?

Are immunizations current? ◯ Yes ◯ No

MEDICATIONS

Please list all current medications and/or supplements your child/adolescent is currently taking:

(Attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

List any emergency room visits (age, reason):

FAMILY/MEDICAL HISTORY

Were there any complications with the pregnancy of this child/adolescent that might have impacted his/her prenatal health or development? (e.g.: mother had significant illness, smoked cigarettes, drank alcohol, experienced severe bleeding, etc.)
◯ Yes ◯ No

Were there significant problems with his/her health or development in the first few years of his/her life?
(e.g: needed to be revived at birth, failure to thrive, or missed significant developmental milestones) ◯ Yes ◯ No

If yes, please explain:

Biological Father's Name: _____ **Age**:_____ **Education**:_____

Occupation: _____ **Deceased**? ◯ Yes ◯ No (If yes, when? _____)

Description of relationship between father and child/adolescent:

Biological Mother's Name: _____ **Age**:_____ **Education**:_____

Occupation: _____ **Deceased**? ◯ Yes ◯ No (If yes, when? _____)

Description of relationship between mother and child/adolescent:

Has anyone in your child/adolescent's extended family (ex: parent, grandparent, uncle/aunt) had a psychiatric illness?
◯ Yes ◯ No

If yes, please describe to the best of your ability (Who, symptoms/diagnosis, were they hospitalized?)

Has anyone in your child/adolescent's family attempted suicide? ◯ Yes ◯ No

If yes, who?

Has anyone in your child/adolescent's family had a problem with or been treated for substance abuse problems?

◯ Yes ◯ No If yes, who?

Feel free to list any additional information you feel may be helpful to the clinician who will be working with your child/ adolescent:

Completed by:_____ Date: _____

(Please sign your name)