ALMA MILLER COUNSELING

LEARN. GROW. HEAL. LIVE.

CONFIDENTIAL

CHILD/ADOLESCENT INITIAL INTAKE FORM

Please provide the following information for your child/adolescent. It is essential that you are as accurate and truthful as possible.

Today's Date: _____ Referred by: _____

Main area of concern: _____

_____

Child's name: _____ Age: _____ DOB: _____

Do you have the right to bring your child in for counseling?: YES NO

Address where child lives: _____

Who does the child live with? ___mother ___father ___both ____stepmother _____stepfather

Parent Name: _____ DOB: _____

Specify if: __biological __step __guardian

Occupation: _____ Place of Employment _____

work #_____ cell #_____

Parent Name: _____ DOB: _____

Specify if: __biological __step __guardian

Occupation: _____ Place of Employment _____

work #_____ cell #_____

May we send communicate through email? YES NO

Preferred Email: _____

Who lives in your household?

_____

_____

_____

Please list names, ages, gender of all siblings.

_____

_____

_____

Who is your child's Pediatrician?: _____

Date of last visit: _____

Phone Number: _____

Address: _____

PREGNANCY:

Is this child your: Biological child _____ Adopted child _____ Foster child _____

Was your child a planned pregnancy? Yes/No

Vaginal or C-Section? Weeks of gestation _____ Please list any delivery complications:

_____

DEVELOPMENTAL MILESTONES: Please list all ages that you can accurately recall.

1. Eating: _____bottle fed _____breast fed
2. Sat up at _____
3. Sleeping habits _____
4. Crawled at _____
5. Walked at _____
6. Smiled at _____
7. Used complete sentences _____
8. Learned to ride a bike _____

Childhood Illnesses: _____

Surgeries: _____

Injuries: _____

EDUCATION BACKGROUND:

1. What school is your child attending? _____Grade:_____

2. Has your child ever had to repeat a grade? If so, which grade?_____

3. Has your child ever been suspended or expelled from school? If so, which grade?_____

If yes, please explain : _____

_____

4. Please record your child's schooling history below:

Schooling Level	Name of School	Grade(s) Attended
Day Care		
Elementary School		
Middle School		
High School		

MEDICAL BACKGROUND:

1. Has your child received any type of mental health services (psychotherapy, counseling, medication, psychiatric services)? ___No ____Yes: Please list: _____
2. Name of previous therapist: _____ Phone: _____
3. Was previous counseling successful? _____
4. Is your child currently taking any medications? ____No ____Yes
5. Prescribing Physician's name: _____

   If yes, please list name(s) and dosage/milligrams:

   _____

   About how long has your child been on these medications? _____

6. Does your child complain of pains, stomachaches, headaches, tiredness?_____
   Please explain: _____

Biological Family Mental Health History: (Please include yourself and distant relatives)

Condition	Please circle	List Family Member(s)	Paternal Maternal
Alcohol/Substance Abuse	Yes / No		
Anxiety	Yes / No		
Autism	Yes / No		
Depression	Yes / No		
Developmental Delays	Yes / No		
Eating Disorders	Yes / No		
Obsessive Compulsive Disorder	Yes / No		
Schizophrenia	Yes / No		
Suicide/suicide attempts	Yes / No		
Odd/Bizarre behaviors	Yes / No		

SOCIAL AND PEER DEVELOPMENT SILLS:

1. Is your child/teen struggling academically in school? No _____Yes _____; List subject(s)?
_____

2. How much time does your child/teen spend on video games in a week? _____hours

3. Does your child/teen use the internet without supervision?_____

4. Does your child/teen seem to enjoy things other children/teens their age enjoy? _____

5. Does your child/teen have difficulty making friends? _____

6. Does your child/teen have difficulty communicating or socializing with others?
_____

7. Is he or she heavily interested in a particular topic or activity? If so, explain:
_____
_____

8. Has your child/teen ever self-harmed? No ____ Yes_____; Explain
_____
_____

PARENTING: Please share a general overview of your relationship with your child/teen:
_____
_____

1. What are your methods of discipline regarding your child/teen?

   ___ grounding ___ spanking ___ lectures ___ yelling ___ take away privileges ___ other _____

2. Are you open and willing to learn new effective strategies in handling difficult behaviors? _____

3. Has your child/teen ever been cruel to animals? _____No _____Yes
   Details:_____

4. What is your family's faith or spiritual belief? _____
5. Would you like prayer to be incorporated in your child's/teen's sessions? __yes __no
6. What do you consider to be your strengths as a parent?

   _____

7. What do you consider to be areas where you can grow as a parent?

   _____

8. What do you consider to be your child/teens strengths?

   _____

9. What do you consider to be areas where your child/teen can improve and grow?

   _____

10. Please share any significant life changing events that have occurred in the past three years, including; marriage, divorce, new baby, domestic violence, financial hardships, a move, new school, death of a loved one or close family friend?

    _____

    _____

    _____

    _____

ABUSE: Has your child/teen had any experiences of abuse or neglect?

___physical ___sexual ____ verbal Details:

_____

_____

_____

_____

CONCLUSION:

1. Describe what has already been done to try and resolve the situation you are coming to counseling for:

   _____

   _____

   _____

2. What do you hope to gain from counseling and what specific areas of concern would you like addressed?

   _____

   _____

   _____

Please explain any other details you would like to share:

_____

_____

_____

OFFICE USE - PLEASE DO NOT WRITE BELOW

Recommendations:

Frequency: Weekly Biweekly Monthly Consult Only

Special Notes:

_____

_____

Recommended Goals:

1._____

2._____

3. _____