# NEW CLIENT INTAKE FORM (CHILD/ADOLESCENT)

*Please provide the following information and answer the questions below; print the form and bring it to your first session. Please note that the information you provide here is protected as confidential information.*

Child's Name:

Name of parent/guardian:

Age: Date of Birth: Gender: ☐ Male ☐ Female ☐ Other

Address: STREET

CITY STATE ZIP

Home Phone: May we leave a message? ☐ Yes ☐ No

Cell Phone: May we leave a message? ☐ Yes ☐ No

E-mail: May we email you? ☐ Yes ☐ No

***Please note that e-mail correspondence is not considered to be a confidential medium of communication.**

Referred by:

Has your child previously received any type of mental health services?

☐ No ☐ Yes, previous therapist/practitioner:

Is your child currently taking any prescription medication?

☐ No ☐ Yes, name/dosage:

Has your child ever been prescribed psychiatric medication?

☐ No ☐ Yes, name/dosage:

What would you like your child to accomplish in therapy?

## FAMILY INFORMATION

1. Please complete the following information for family members living in the home:

| Name | Age | Sex | Rel'p to child | Education | Problems |
|---|---|---|---|---|---|

2. Please complete the following information for family members living outside of the home:

| Name | Age | Sex | Rel'p to child | Education | Problems |
|---|---|---|---|---|---|

3. Parents are ☐ Married ☐ Separated ☐ Divorced ☐ Deceased
4. Child is ☐ Adopted ☐ Step-child ☐ Foster child ☐ Biological
5. What is the primary language spoken in the home?
6. Has any family member experienced any major changes or stressful events in the recent past? ☐ No ☐ Yes, please explain:

7. Do any family members suffer from the following illnesses?

| **ILLNESS** | **✓ IF AN ISSUE** | **REL'P TO CLIENT** |
|---|---|---|
| Alcohol/Substance Abuse | ☐ | |
| Anxiety | ☐ | |
| Depression | ☐ | |
| Domestic Violence | ☐ | |
| Eating Disorders | ☐ | |
| Obesity | ☐ | |
| Obsessive Compulsive Behavior | ☐ | |
| Schizophrenia | ☐ | |
| Suicide Attempts | ☐ | |

## GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current child's physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific, current health problems:

2. How would you rate your child's current sleeping habits?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good
Please list any specific sleep problems your child is currently experiencing:

3. Has your child been known to drink alcohol? No Yes, describe:

4. Has your child been known to use recreational drugs? ☐ No ☐ Yes, describe:

5. Has your child experienced any significant life changes or stress recently?

6. Does your child suffer from any neurological, genetic, or other chronic illness or condition? ☐ No ☐ Yes, explain:

7. Has your child ever felt like life is not worth living or expressed a desire to harm him/herself? ☐ No ☐ Yes, explain:

## EDUCATIONAL INFORMATION

1. Name of child's current school:
2. Type of school: ☐ Public ☐ Private ☐ Charter 3. Grade:

4. What grades does your child receive?
5. Have there been any significant recent changes in grades or behaviors at school? ☐ No ☐ Yes, describe:

## SOCIAL & RECREATIONAL INFORMATION

1. Does your child have friends? ☐ No ☐ Yes
2. Does your child have a best friend? ☐ No ☐ Yes
3. What types of activities does your child enjoy?
4. Does your child currently belong to any organized clubs, groups or sports? ☐ No ☐ Yes:
5. What do you feel are your child's most positive behavioral characteristics?

6. What behaviors concern you most?

7. Is your child spiritual or religious? ☐ No ☐ Yes

## LIMITS OF CONFIDENTIALITY

*Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:*

**Duty to Warn and Protect:** When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. **Abuse of Children and Vulnerable Adults:** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities. **Prenatal Exposure to Controlled Substances:** Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. **Minors/Guardianship:** Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

**Insurance Providers** (when applicable): Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

***I agree to the above limits of confidentiality and understand their meanings and ramifications.***

**Parent/Guardian Signature** **Today's Date**

**Parent/Guardian Printed Name**