Pecosh Counseling & Consulting LLC

Counseling with a sense of humor!

Intake Form for Children & Adolescents

Name: ____
(Last) (First) (Middle Initial)

Birth Date: _________/_________/__________ Age: __________

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Name of parents/guardians:

____
(Last) (First) (Middle Initial)

____
(Last) (First) (Middle Initial)

My cell Phone: (________)_____________ May we leave a message? _______

Child's home Phone: (_______)_________________ May we leave a message? ______

Email: ________________________________ May we email you? ________
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Please list any siblings/ages:

____

How did you hear about us?

- ☐ Friend ☐ Other: ____
- ☐ Family Member
- ☐ Google or other search engine
- ☐ Insurance Company

School your child currently attends:________________________________Grade:_______

Would you like the therapist to contact the school regarding your child?* ☐ Yes ☐ No

*The therapist will discuss this with you, and you will need to sign a consent if you'd like him or her to speak to someone at the school.

Has your child ever been disciplined at school for his or her behavior? ☐ Yes ☐ No

If so, please describe (e.g., suspended, given detention, expelled, etc. for fighting, disrespect, back talk, etc.):____

____

____

What is your child's current academic standing? ☐ A student ☐ B student
☐ C student ☐ Currently failing or in danger of failing some classes

Has your child ever previously received any type of mental health services (e.g., psychotherapy, psychiatric services, Wraparound, etc.)?
☐ No
☐ Yes, previous therapist/service and dates (e.g., Wraparound in 2012):

____

____

Is your child currently taking any prescription medication?
☐ No
☐ Yes, please list:

____

____

Has your child been prescribed psychiatric medication in the past that he/she no longer takes?
☐ No
☐ Yes, please list and provide dates (e.g., Concerta, 2013):

____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child's current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems he/she is currently experiencing:

____
____

2. How would you rate your child's current sleeping habits? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific sleep problems your child is currently experiencing:

   ____
   ____

3. How many times per week does your child generally exercise?
   ____

   In what types of exercise/sport does your child participate?
   ____
   ____

4. Please list any difficulties your child experiences with appetite or eating patterns.
   ____

5. Is your child currently experiencing sadness, grief or depression?
   - ☐ No
   - ☐ Yes

   If yes, for approximately how long? ______________________________________

6. Is your child currently experiencing anxiety, panic attacks or have any phobias?
   - ☐ No
   - ☐ Yes

   If yes, when did he/she begin experiencing this? __________________________

7. Is your child currently experiencing any chronic pain?
   - ☐ No
   - ☐ Yes

   If yes, please describe: ____

8. Do you suspect that your child has experimented with alcohol?
   - ☐ No ☐ Not applicable due to age
   - ☐ Yes

9. Do you suspect that your child has experimented with recreational drugs?
   - ☐ No ☐ Not applicable due to age
   - ☐ Yes

10. Is your child currently in a romantic relationship?
    - ☐ No ☐ Not applicable due to age
    - ☐ Yes

    If yes, for how long? ____

On a scale of 1 (poor) - 10 (great), how would you rate your satisfaction with your child's choice of boyfriend/girlfriend?

____

11. What significant life changes or stressful events has your child experienced recently?

____
____
____
____
____

FAMILY MENTAL HEALTH INFORMATION

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disorders	Yes / No	

	Please Circle	List Family Member
Obesity	Yes / No	
Obsessive Compulsive Behavior	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	

Please complete the following: My child is:
- ☐ My full biological child
- ☐ Adopted and aware of it
- ☐ Adopted and unaware of it
- ☐ Other (please explain):______________

____

____

Has your child ever witnessed domestic abuse? If yes, please circle all that apply:
- ☐ No
- ☐ Yes — Emotional Physical Verbal
- ☐ Unsure

Has your child ever experienced abuse or neglect? If yes, circle all that apply:
- ☐ No
- ☐ Yes — Emotionally Physically Sexually Verbally
- ☐ Unsure

If you are comfortable writing about the abuse, please share whatever you would like to share about it (by whom, when did it occur, for how long, etc.):

____

____

____

____

ADDITIONAL INFORMATION

1. Are you—the child's parent/guardian—currently employed?
   - ☐ No
   - ☐ Yes

   If yes, what is your current job title; what do you do?

   ____

   Is your child employed?
   - ☐ No
   - ☐ Not applicable due to age
   - ☐ Yes ______________________________

2. Do you consider your family to be spiritual or religious?
   - ☐ No
   - ☐ Yes

   If yes, describe your family's faith or belief.

   ____

   ____

   Is your child actively involved in the family's faith or belief? If so, please describe (e.g., attends youth group, goes to weekly services, altar server):

   ____

   ____

3. What do you consider to be some of your child's strengths?

   ____

   ____

   ____

4. What do you consider to be some of your child's limitations?

   ____

   ____

   ____

5. What would you like to see your child accomplish with his/her time in therapy?

   ____

   ____

   ____

Please write anything else that you wish the therapist to know:

____

____

____

____

____

____

____

____

____

____