Hope Forward
COUNSELING + COACHING

CHILD INTAKE FORM

(Please complete in Ink)

CHILD

1. Child's Name_____Sex_____Age_____DOB___
   Phone (Cell): _____ Can we leave messages at this number?_
2. Natural Child Yes / No If adopted, at what age_____ Foster since _____

3. Parent's Names (include stepparents, foster parents, etc.)

_____

_____

4. Please note any custody or visitation arrangements or concerns (if applicable):

_____

_____

PRESENTING ISSUES

Briefly describe the presenting issue(s) for which you are seeking therapy for your adolescent.

_____
_____

What would you like to see happen as a result of therapy?

_____
_____

What is most concerning right now?

_____
_____

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child?
❒ Yes ❒ No *If yes, please describe:*

_____
_____

Did your child have health problems at birth? ❒ Yes ❒ No *If yes, please describe:*

_____
_____

Has your child experienced any developmental delays (e.g. toilet training, walking, talking)?

❒ Yes ❒ No ❒ Unsure *If yes, please describe:*

_____
_____

Did your child display any developmentally unusual behaviors or problems prior to age 3?
❒ Yes ❒ No ❒ Unsure *If yes, please describe:*

_____
_____

Has your child experienced emotional, physical, or sexual trauma?
❒ Yes ❒ No ❒ Unsure *If yes, please describe:*

_____
_____

SYMPTOM/PROBLEM CHECKLIST

Please place a checkmark in the appropriate box for each of the following that you might be feeling:

Symptom	None	Mild	Mod	Severe	Symptom	None	Mild	Mod	Severe
Sadness					Social Isolation				
Cries Easily					Paranoid Thoughts				
Problems at home					Indecisiveness				
Hyperactivity					Low Energy/Fatigue				
Binging/Purging					Excessive Worry				
Loneliness					Poor Concentration				
Unresolved Guilt					Low Self-worth				
Irritability					Anger Issues				
Nausea/Indigestion					Identity Questions				
Social Anxiety					Hallucinations				
Self-harm/Cutting					Racing Thoughts				
Impulsivity					Restlessness				
Nightmares					Drug Use				
Hopelessness					Alcohol Use				
Elevated Mood					Easily Distracted				
Mood Swings					Trauma Flashbacks				
Anorexia					Obsessive Thoughts				
Grief					Panic Attacks				
Phobias					Feeling Anxious				
Headaches					Feeling Panicky				
Change in Weight					Suicidal Thoughts				
Change in Appetite					Homicidal Thoughts				

Difficulty Sleeping					Bullied by Peers				
Excessive screentime					Difficulty at school				
Reclusive					Tantrums				
Aggressive Behavior					Running Away				
Lack of interest in activities					Other:				

_____

_____

TREATMENT/MEDICAL HISTORY

Has your child previously seen a therapist? ❒ Yes ❒ No *If yes, where:* _____
Approximate dates of counseling: _____ For what reason(s) did your child attend therapy? _____ Has your child accessed psychiatric services? ❒ Yes ❒ No *If yes, where:* _____
Has your child been treated at a higher level of care for mental health reasons? (e.g. inpatient, residential, partial, intensive outpatient program?)_____ Does your child have a previous mental health diagnosis? ❒ Yes ❒ No ❒ Unsure
If yes, please specify:

_____

What did you find **most helpful** about their treatment?

_____
_____

What did you find **least helpful** about their treatment?

_____
_____

Has your child taken medication for a **mental health** concern? ❒ Yes ❒ No
If yes, please indicate names, dosages, and dates:

_____
_____

Does your child have other **medical** concerns or previous hospitalizations? ❒ Yes ❒ No
If yes, please describe.

_____
_____

Please list all the people in what you would describe as your immediate family:

NAME	RELATIONSHIP TO CHILD	AGE	SEX	TYPE (BIO, STEP, ADOPTIVE)	LIVING WITH CHILD? Y/N

SCHOOL HISTORY

1. Present School: _____Grade: _____Teacher:_____
2. Has your child ever repeated any grade? _____
3. Is your child in special education services? No ____ Yes, what kind? _____
4. Please describe academic or other problems your child has had in school.

_____

YOUR CHILD'S STRENGTHS

What activities do you feel your child enjoys?

_____
_____

What positive personal qualities does your child have?

_____
_____

Who are some of the influential and supportive people, activities, or beliefs in your child's life?
Please describe:

_____
_____

Is there anything else you would like to share?

_____
_____
_____

Special Confidentiality Notice for Parents

We strongly believe that for therapy to be helpful to an adolescent, there needs to be as much confidentiality for them as possible in the therapy process. That is, unless the issue falls into the following categories…

--your child is clearly unsafe or at risk of harming themselves

--your child is at risk of being harmed by anyone else

--your child is at risk of harming someone else

--we are required by a court to disclose treatment records

…in which case we would follow the clinically and legally appropriate reporting requirements. Outside of this, we will encourage your child to express themselves freely, and assure them that there will be confidentiality provided to them in this process. We need your child to be open and honest with us to understand and treat the full range of issues your child is facing, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare, and support your child so that they feel safe enough to share those issues with you, and we are happy to facilitate family meetings whenever helpful and appropriate.

Person completing form for client:

Printed Name: _____ Signature: _____

Relationship: _____ Date: _____