3501 5th Avenue Ste. A
Lake Charles, Louisiana 70607
337-429-5129

CHILD/ADOLESENT INTAKE FORM

Today's date: _____

Patient Information:

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____

Phone Number:_____ Email:_____

Race: _____ Gender: M/F School_____ Grade_____

Parent/Guardian Information:

Name of Mother/Legal Guardian_____ Age _____ Phone_____

Place of Employment _____

Name of Father/Legal Guardian_____ Age_____ Phone_____

Place of Employment _____

Marital Status of Parents/Guardian(s): Single Married Divorced Separated Widowed

Who does the patient live with? _____

Name of Person Completing this form: _____

Relationship to patient: _____

Primary Insurance:

Name of Insurance_____ Policy Number_____ Group No._____

Name of Guarantor_____ Relationship to Patient_____

SS No. of Guarantor _____ DOB of Guarantor _____

Secondary Insurance:

Name of Insurance_____ Policy Number_____ Group No._____

Name of Subscriber_____ Relationship to Patient_____

SS No. of Subscriber _____ DOB of Subscriber _____

Emergency Contact:

Name: _____ Relationship to Patient _____ Phone _____

Referral Information:
Who referred you to this office?

_____
(name) (phone)

Presenting Problem: (What brings you to the office?)
_____
_____
_____
_____

How has this problem affected the child's ability to function at home, school, and/or in the community?
_____
_____
_____

What do you hope to accomplish in counseling?
_____
_____
_____
_____

Have you recently worried that the child has:

☐ Yes ☐ No DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in things, etc.)

☐ Yes ☐ No BIPOLAR DISORDER (extreme changes in mood ranging from depression to anger)

☐ Yes ☐ No ANXIETY DISORDER (worries, restless, scared, obsessive thoughts.)

☐ Yes ☐ No CONDUCT DISORDER (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)

☐ Yes ☐ No ATTENTION/HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)

☐ Yes ☐ No ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)

☐ Yes ☐ No SOCIAL ANXIETY (shy and/or afraid to be around others)

☐ Yes ☐ No POST-TRAUMATIC STRESS DISORDER (frequent nightmares, intrusive and/or current memories)

☐ Yes ☐ No AUTISM (social, behavioral and language impairments, odd behaviors,)

☐ Yes ☐ No ADJUSTMENT DISORDER (problems coping with life problem, or changes in situation)

☐ Yes ☐ No PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)

☐ Yes ☐ No DISSOCIATION (feeling outside of self or things are not real, etc.)

☐ Yes ☐ No SUICIDAL (thoughts of hurting self, attempts to hurt self)

☐ Yes ☐ No HOMICIDAL (thoughts of hurting others, attempts to hurt others)

Please list any current or prior outpatient psychiatrists, psychologists, counselors or social workers the child has seen?

Name	Title	Location	How Long?

Current Medications:
Please list all current medications currently taken

Name	Dose	Response/Side Effects

Drug Use History:
Does this child have any history of drug use that you are aware of? If so, which drug(s) has the child used?

Family History:

Review the list below – if any relative has one of these disorders, check the disorder and describe their relation to your child (such as "Maternal Grandmother"). Maternal is mother's side of the family and Paternal is father's side of the family. Consider this individual's immediate family on both sides (parents, grandparents, brothers, sisters, aunts, uncles & 1st cousins)

_____ Depression_____
_____ Anxiety_____
_____ ADHD_____
_____ Bipolar (manic depressive)_____
_____ Schizophrenia_____
_____ Psychiatric Hospitalizations_____
_____ Suicide (or attempts)_____
_____ Pertinent Medical Problems_____

Developmental History:

Did your child achieve the following milestones early (E), average (A), or late (L) compared with others his/her age (please explain if late):

_____ Language (age at first using words, sentences, etc…)?

_____ Fine motor skills (building towers with cubes, drawing circle)

_____ Gross motor skills (rolling over, standing, walking)?

_____ Toilet training?

Has your child experienced any regression of these? ☐ Yes ☐ No
If yes, explain: _____

Physical Health History:

Primary Care Provider: _____ Medical Specialty: _____
Phone: _____
Address: _____
Approximate Date of Last Visit: _____

Allergies (drug, food, seasonal, environmental etc.)? ☐ Yes ☐ No If yes, please name and describe your child's reaction: _____

Does the patient have any chronic medical problems? ☐ Yes ☐ No If yes, please describe: _____

Does the patient have a history of any serious injuries or medical hospitalizations? ☐ Yes ☐ No
If yes, please describe: _____

Household: Please list all members of the household

Name	Education/Grade	Occupation	Relationship with Child (quality)

Abuse History:
Has the child ever been the victim of abuse or neglect? ☐ Yes ☐ No
If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical Emotional Neglect
Sexual Victim of Violent Crime Witnessing violence
Please explain _____

Are you struggling with your marriage/relationship or parenting? ☐ Yes ☐ No
If yes, please describe: _____

Has your child ever been involved with the following and if yes, please explain:
☐ Yes ☐ No Child Protective Services _____
☐ Yes ☐ No Probation/Juvenile Probation/Detention _____
☐ Yes ☐ No Early Intervention Services (ages 0-3) _____

School:
What are his/her typical grades? _____
What are your child's academic strengths? _____
Academic weaknesses? _____

Has there been a change in your child's performance at school? ☐ Yes ☐ No If yes, please describe: _____

Does your child have an IEP? ☐ Yes ☐ No
504 Plan ☐ Yes ☐ No

Has the patient had problems with any of the following?
☐ Yes ☐ No Truancy, explain: _____
☐ Yes ☐ No Fights, explain: _____
☐ Yes ☐ No Absenteeism, explain: _____
☐ Yes ☐ No Detention, explain: _____
☐ Yes ☐ No Suspension, explain: _____
☐ Yes ☐ No School refusal, explain: _____

Peers:
Does your child have quality relationships with other children? ☐ Yes ☐ No If no, please explain: _____

Culture:
Do you have a religious preference in the household? ☐ Yes ☐ No If yes, what is that preference? _____

Has your child experienced any problems related to race, religion, or culture? ☐ Yes ☐ No If yes, please explain: _____

TEEN/YOUNG ADULT SECTION (13-17 years)

Do you have any concerns regarding your adolescent's friendships/relationships? ☐ Yes ☐ No (If yes, please explain): _____

Has the patient had a recent change in friendships? ☐ Yes ☐ No If yes, what changes, if any are concerning to you? _____

Are you concerned about your child's sexual activities ☐ Yes ☐ No _____
Is your adolescent sexually active? ☐ Yes ☐ No _____
Does your adolescent have a job? ☐ Yes ☐ No _____
Has your adolescent's behavior ever resulted in police, detention, or court involvement? ☐ Yes ☐ No
If yes, please explain: _____

Is there anything else you would like us to know about the patient? _____