New Dawn Counseling Center
Child and Adolescent Intake Form
CONFIDENTIAL

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. ***This form is to be completed by parent or guardian requesting services for a minor child***.

Child's Name: _____Date of Birth _____Age _____Sex_____

Child's Present Address_____

_____

City *County* *State* *Zip Code*

Parents'/Guardian's Ph: Wk: _____ Cell: _____Home: _____

Child lives with: Both biological parents_____ Mother_____ Father____ Mother & Stepfather_____

Father & Stepmother_____ Other (specify) _____

If 'Other', explain (including arrangements/decisions which led to child living with you and length of time child has lived with you): _____

_____

_____

If parents are divorced, describe custody arrangements: (***a copy of the custody agreement may be required before counseling will be conducted):*** _____

_____

Child's Ethnicity: _____

Emergency contact name/number/relationship:_____

_____

Have there been any previous psychological, psychiatric, neurological or E.E.G. evaluations? Yes No

If yes, please list names, addresses, and dates of contact (use extra paper if necessary): _____

_____

_____

Has child had counseling previously? Yes No

If yes, please list names, addresses, and dates of contact (use extra paper if necessary): _____

_____

_____

_____

MEDICAL HISTORY

Were there any complications surrounding the child's birth? Yes_____ No_____

If yes, describe: _____

_____

List child's sicknesses, operations, injuries. Indicate age when occurred and describe severity. Please pay special attention to head injuries, any time your child was unconscious, had convulsions, high fever or was delirious:

_____

_____

_____

_____

_____

List any current medical problems your child is experiencing: _____

_____

_____

_____

List any prescription drugs child is currently taking: _____

_____

_____

Date of Child's last physical exam: _____
Child's Physician Name and Address:

_____

_____

_____

How is child's vision? _____Hearing: _____

ACADEMIC / SCHOOL INFORMATION

Name of school: _____ Grade:____Teacher: _____
Previous schools attended with dates: _____

_____

_____

Has child ever repeated a grade? Yes No If yes, which ones: _____
How does your child get along at school? _____

_____

Describe difficulties in learning at school: _____

_____

_____

List other family members who had learning difficulties: _____

_____

Child's special interests/hobbies: _____
Child's church affiliation and activities: _____

_____

_____

LEGAL INVOLVEMENT

Is the child involved with the legal/court system? Yes ___ No____
If yes, explain: _____

_____

_____

_____

Probation/Parole Officer Name and Phone Number: _____

_____

INFORMATION ABOUT CHILD'S MOTHER:

Mother's Name/Address: _____

_____

Employer: _____ Occupation: _____
Employer's Address: _____

_____

Can you be contacted at work by phone? Yes No
Work Ph: _____ Cell: _____Hm:_____
Religious Affiliation/Church: _____

Member: Yes No Active: Yes No
Ethnicity_____
Any physical problems that require medication or physical care: _____

_____

Current medications: _____

_____

Physician(s): _____
Previous counseling/therapy? Yes No If yes, when and therapist's name: _____

_____

INFORMATION ABOUT CHILD'S FATHER:

Father's Name/Address: _____

_____

Employer: _____ Occupation: _____

Employer's Address: _____

_____

Can you be contacted at work by phone? Yes No

Work Ph: _____ Cell: _____ Hm: _____

Religious Affiliation/Church: _____

Member: Yes No Active: Yes No

Ethnicity_____

Any physical problems that require medication or physical care: _____

_____

_____

Current medications: _____

_____

Physician(s): _____

_____

_____

Previous counseling/therapy? Yes No If yes, when and therapist's name: _____

_____

INFORMATION ABOUT CHILD'S GUARDIAN (if not mother/father listed above):

Guardian's Name/Address: _____

_____

_____

Employer: _____ Occupation: _____

Employer's Address: _____

_____

Can you be contacted at work by phone? Yes No

Work Ph: _____ Cell: _____ Hm: _____

Religious Affiliation/Church: _____

Member: Yes No Active: Yes No Ethnicity_____

Any physical problems you have that require medication or physical care: _____

_____

_____

Current medications: _____

_____

Physician(s): _____

_____

Previous counseling/therapy? Yes No If yes, when and therapist's name: _____

_____

_____

FAMILY MEMBERS

List all people now living in the child's household, then draw a line and list others who have lived there during the child's lifetime. Use a separate sheet of paper if necessary:

Name Relationship to child Age Occupation Date lived with child

Using the scale below, please choose a number that reflects the extent of your concern for your child about each of the issues listed below. Please rate every item.

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

_____ Anger/Temper
_____ Depression
_____ Divorce/Separation of parents
_____ Adjustments to Parents Remarriage
_____ School Performance
_____ Family Problems
_____ Fearfulness
_____ Physical problems
_____ Problems with social relationships
_____ Problems sleeping
_____ Nightmares
_____ Sexual Concerns/Behaviors
_____ Religious/Spiritual Concern
_____Trouble focusing/concentrating
_____ Talk of suicide
_____ Unhappy most of the time
_____ Use of alcohol/drugs (circle if applicable)
_____ Work
_____ Worry
_____ Self Esteem
_____ Poor Appetite
_____ Overeating/not eating/throwing up (circle)
_____ Bedwetting
_____ Soiling
_____ Cruelty to Animals
_____ Fire Setting
_____ Fighting

_____ Other (specify): _____

Briefly describe the problem which prompted you to seek counseling for your child at this time:

_____

_____

_____

_____

_____

_____

Have there been times when the problem got better or disappeared? Yes _____ No _____

If yes, when? _____

What do you think helped? _____

_____

_____

Were there times when the problems were especially bad? Yes _____ No _____

If yes, when? _____

What made it bad? _____

_____

_____

Are there other people who play a major role in causing the problems? Yes _____ No _____ Explain briefly:_____

_____

_____

Are there other people who play a major role in helping your child cope with the problems? Yes ___ No ____

Explain briefly:_____

_____

_____

Is there anything else that you believe might be important for the counselor to know at this time? _____

_____

_____

_____

Custodial Parent/Guardian Signature Date

Aug 2010