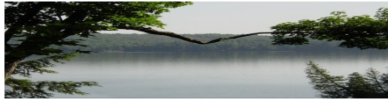

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Child and Adolescent Intake Assessment

Child's Name _________________________________ DOB __________ Date __________
Case ID # _______________ County __________________ Person ID #________________
Gender: __M __F Ethnicity: __Caucasian __ African- American __ Hispanic __
__ Asian ___ Bi-Racial ___ Multi-Racial __ Other

Individuals participating in assessment:

____

Responsible Party Information

Responsible Party Name

____

Relationship to client

____

Phone Number: ____

Current custody status: ___ Parents ___ Sole Parental Custody ___ Joint Legal Custody
___ DCPP Custody ___ Other: __________________________________

List all persons authorized to bring this child to therapy sessions and include a copy of the person's driver's license:

____
____

Current Treatment Focus
What brings you and your child/client to our office today?
____
____
____
____
____

What services are you seeking?
___ Individual Therapy ___ Psychological Testing ____ Supervised Therapeutic Visitation
___ Family Therapy ___ Group Therapy: (*name of group*) ___________________________
___ Other (*explain*): ____

I/we would like to address the following: (check all that apply)
___ My child's/client's mood or emotional state ___ My child's/client's behavior
___ My child's/client's school performance
___ My child's/client's sleep, eating, or physical concerns
___ My child's/client's cognitive/mental functioning
___ My child's/client's relationships with family or peers
___ Parenting ___ Family relationships ___Grief/Loss
___ Divorce ___ Other: ________________________________

Household Information

Client's Address
____

Client's current living situation:
___ At home with parents/guardians ___ With other family ___ Foster care
___ Residential placement ___ Other (explain) _________________________________

Please list all members of the household:

Name/ Relationship to Client
____ ________________
____ ________________
____ ________________
____ ________________
____ ________________
____ ________________
____ ________________

Please list any other significant family members who do not live with client:
____
____

Developmental History

Was your child/client: ___ Planned ____ Natural Conception ___In Vitro ____ Adopted
___ Breast Fed ___ In Day Care
___ Unplanned ___ Bottle Fed ___ Kept at Home
___ Exposed to medications/drugs/alcohol in the womb
___ Difficult or high-risk pregnancy or delivery
Was your child healthy at birth? ___ Yes ____ No

If not, what were the specific complications:
____
____?

At what age did your child/client: Talk ________ Walk _________ Potty Train _________

Describe any developmental delays (e.g., speech, socialization, emotional, etc):____
____
____
____

Does the child/client have difficulty separating from caregivers? ___ Yes ___ No

Does the child/client have contact with extended family members? ___Yes ___ No

Has your child/client experienced any of the following traumatic events? (Please explain)

___ Death____
___ Separations____
___ Violent Behavior____
___ Physical Abuse____
___ Emotional Abuse____
___ Sexual Abuse____
___ Verbal Abuse____
___ Pornographic Material____
___ Domestic Violence: The client's parents/guardians/adults in the home:
___ hit/push/shove each other….witnessed by child? Yes___ No___
___ yell/scream/raise their voices/say mean things…. witnessed by child? Yes___ No___
___ throw or break things in the home…. witnessed by child? Yes___ No___
___ Parental Impairment (physical or mental)_________________________________
___ Cruelty to animals____
___ Natural Disaster____
___ Other Traumatic Event____

Has your child/client experienced any of the following problematic behaviors? (Please explain)

___ Accused/suspected of illegal activity____
___ Convicted of illegal activity____
___ Incarcerated for illegal activity____
___Accused/suspected of sexual offenses____
___Accused/suspected of substance use____
___Accused/suspected of drug trafficking (e.g. selling)______________________________
___ Accused/suspected of human trafficking (e.g. prostitution)__________________________
___ Self- injury/self- harm____
___Thoughts of killing self, intent, plan____
___ Thoughts of killing or harming others, intent, plan______________________________
___ History of violent behavior____
___ Running away from home/primary residence______________________________
___ Cruelty to or hurting animals____
___ Bed- wetting____
___ Refusing to Eat/ Overeating____
___ Fire- setting____
___ Nightmares/ night terror____
___Other problematic behavior____

Education History

School Name

____

Teacher Name(s)

____

Grade Level _______ Academic Performance: ___ Excellent ___ Good ___ Fair ___ Poor ___ ____Failing

IEP in place? ___ No ___ Yes (If yes, please explain):______________________________

____

Are there any problems with absenteeism?
___ Yes ___ No If yes, please explain:______________________________

____

____

Behavior in school towards authority figures/teachers:
___ Excellent ___ Good ___ Fair ___ Poor ___ Failing

Behavior in school towards peers: ___ Excellent ___ Good ___ Fair ___ Poor ___ Failing

Plays well with others: ___ Excellent ___ Good ___ Fair ___ Poor ___ Failing

Prefers being alone: ___ Yes ___ No

Has/had a best friend: ___ Yes ___ No

Hangs out with a group of friends: ___ Yes ___ No

Frequent changes in peer group: ___ Yes ___ No
Please explain:____
____

Recent change in peer group or friend choice: ___ Yes ___ No
Please explain:____
____

Satisfied with number of friends: ___ Yes ___ No
Please explain:____
____

Satisfied with quality of friends: ___ Yes ___ No
Please explain:____
____

The child's/client's relationships with peers can be described as:

___ good, healthy interactions
___ poor, lots of conflict
___ poor, avoids peers/people
___other (please explain):____
____

The child/client is known as a:

___ follower
___ bully
___ leader

Medical History

Has your child/client experienced any of the following? (Please explain)

___ Severe illness, injury: ____

___ Allergies (foods, drugs, substances): ____

___ Chronic medical problems: ____

___ Significant family medical history: ____

___ Significant family mental health history: ____

___ Prior mental health/developmental diagnosis: ____

Primary Care Physician (name & phone number)

____

Current Medication Name/ Dosage

____

____

____

Treatment History: ***Please list all mental health and substance abuse treatment:***

Facility Name and Phone Number	Therapist Name and Phone Number	Type of Treatment (e.g. inpatient, outpatient, hospitalization, residential, mental health, substance abuse)	Dates of Treatment/ Current (e.g. C) or Past (e.g. P) Treatment	Purpose of Treatment

Response to Treatment:____
____
____
____

Other agency services/ in the last six months (please explain):

___ DCPP ___ Juvenile Justice System ___ IOP: ____
___ Inpatient Hospitalization ___ Outpatient Hospitalization __Other: ______________________
____
____

Household/Family Information (Please explain)

Religious Preference
____
Involved in local church? ___ No ___ Yes:
____

Normal bedtime: __________ Number of hours usually slept: ________________

Where does your child/client sleep?
____
How is your child/ client usually disciplined?
____
Who is the disciplinarian in the client's home?____

Our household is usually (check all that apply)

___ Quiet ___ Calm ___ Highly structured ___ Lots of conflict
___ Noisy ___ Active/Busy ___ More relaxed/unstructured ___ Tense

What activities does your child/client enjoy?

___ Video games ___ Telephone ___ Sports
___ TV /Movies ___ Reading ___ Shopping
___ Internet/computer ___ Art/Crafts ___ Playing outside
___ Being with friends ___ Playing with toys ___ Other _______________________

Is there anything else you would like for us to know about your child's/client's life?
____
____
____
____
____

Child Assessment: Please check all of the following that currently apply to your child/client.

Please indicate past concerns with the letter "P":

____ Anxiety ____ Hurts others ____ Hyperactive ____ Refusing to eat ___ Overeating
____ Depressed mood ____ Lying ____ Attention problems ___ Mood Swings
____ Panic attacks ____ Stealing ____ Worries all the time ___ Concerns with Body Image
____ Racing thoughts or speech ____ Destroying property ____ Impulsive
____ Obsessions/Compulsions ____ Defiance ____ Low self-esteem
____ Excessive fears or phobias ____ Blames others for mistakes ____ Suicidal thoughts
____ Dissociative states ____ Angry/resentful ____ Suicide attempts
____ Touchy/irritable ____ Lack of conscience ____ Self-mutilation
____ Nightmares ____ Bizarre behavior ____ Sexually active / acting out
____ Sleep problems ____ Clingy ____ Difficulty with change
____ Bedwetting or incontinence ____ Separation anxiety ____ Needs predictability/routine
____ Tantrums or "meltdowns" ____ Seems to overreact ____ Unexplainable mood shifts
____ Difficult to parent ____ Parent feels overwhelmed ____ Running away
____ Conflicting parenting styles ____ Argues with adults ____ Deliberately annoys people
____ Parental marital problems ____ Doesn't seem to listen ____ Takes excessive risks
____ Adopted or in foster care ____ Seems adult like or older ____ Seems younger than age
____ Lots of physical complaints ____ Life has been unstable ____ Life changes pending

Substance Use History

Type of Substance	**Age First Used?**	**How much used?**	**Currently (C) or Past (P)?**	**Is this or has this been a problem? Yes or No**
Alcohol				
Tobacco Use (e.g. cigarettes, smokeless tobacco, e-cigarettes, vaping)				
Cannabis (e.g. weed, pot, hash, etc.)				
Opioid Use (e.g. heroin, oxycodone, methadone)				
Stimulant Use (e.g. cocaine, amphetamines,				

Sedative or Hypnotic Use (e.g. Xanax, valium, antianxiety medications, and sleeping medications				
Hallucinogen-Related (e.g. ecstasy, e-pills, PCP, angel dust)				
Inhalant- Related (e.g. glues, fuels, paints)				
Stimulants (e.g. speed,				
Caffeine (e.g. coffee, energy drinks, caffeinated soda, chocolate, weight loss aids)				
Synthetic Drugs (e.g. K2, spice, bath salts				
Other:				

Work History

Is your child/client currently employed? ___ Yes ___ No

If yes, where and how many hours a week?____

____

Legal History

Does your child/client have any legal problems? ___ Yes ___ No

If yes, please answer below:

Problem, charge/citation	Age/ Year it Happened

How did you hear about us?

___ DCPP ___ Attorney: ________________________________
___ Friend/Client ___ Doctor: _________________________________
___ Internet ___ Other agency: ___________________________
___ Court-ordered ___ Other: __________________________________

I certify that the information provided above is correct to the best of my knowledge, and that I am authorized to provide such information on behalf of this client.

____

Signature of Legal Guardian Date

____

Clinician Signature/Credentials Date