BOTH/AND Resources
Child/Adolescent Intake Form

PLEASE COMPLETE AS THOROUGHLY AS POSSIBLE- Under 12 years old, parent(s) complete; 12 years or older, complete for self with assistance from parent(s) as needed.

Name _____ **Age** _____

Date of Birth _____ **Date of Adoption (if applicable)**_____

Referred by _____ **Today's Date** _____

CURRENT SITUATION

Describe the concerns that led you or your parents to seek therapy for your family.

_____
_____
_____

Describe the things that you and your family have already done to try to deal with these concerns.

_____
_____
_____

Describe what you hope to accomplish and changes you would like to make in therapy._____
_____
_____

Name your strengths, areas of interest, things you do well or activities you enjoy. (Under 12: ask your child what things he/she likes to play, likes to read, etc.)

_____
_____
_____

Do you have a best friend – or friends? Do you like school? Do you participate in other activities (e.g. church, sports, arts, etc.)? Are there other important people in your life (not listed elsewhere)?

_____
_____
_____

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HOME

How many homes do you have? _____

Address #1: _____
_____

At this home I live with (list members of household, age, relationship): _____
_____
_____
_____

Address #2: _____
_____

At this home I live with (list members of household, age, relationship): _____
_____
_____
_____

SCHOOL / WORK

Where do you go to school? _____

What grade are you in? k 1 2 3 4 5 6 7 8 9 10 11 12

Do you have a job? Yes No
If so, what do you do? _____

LEGAL ISSUES

Have you been in a shelter, juvenile detention, or other placement? Yes No
If so, where were you placed? _____

Have you had other legal involvements? Yes No
(probation, child protection, first time offender, etc.) _____
_____
_____
_____

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RISK CONCERNS

Have you ever felt like you didn't want to be alive? Yes No
Do you feel that way now? Yes No

Have you, or do you ever, hurt yourself by:
_____ pulling out your hair _____ cutting/stabbing _____ burning
_____driving while drinking _____ driving too fast
_____ eating something you know will make you sick
Has anyone else ever hurt you? Yes No

Have you tried alcohol? Yes No
If so, what happened? _____
_____

Have you tried drugs? Yes No
If so, what drugs? _____
What happened? _____
_____
Do you still use sometimes? Yes No

Have you been in trouble because of using drugs or alcohol? Yes No
with : parents law peers other _____

Do you, or does anyone close to you, have concerns about your use of alcohol or drugs?
Yes Noou
Do you have concerns about the substance use or abuse of anyone close to you?
Yes No
If so, whom? _____ Currently In the past

Have you ever had any treatment for substance abuse? Yes No
If so, where? _____
When? _____

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MENTAL HEALTH HISTORY

Have you ever seen a therapist before? Yes No
If so, name of therapist _____

dates: from _____ to _____
Have you seen a psychiatrist or other doctor for medication? Yes No
If so, name of doctor _____
dates: from _____ to _____

Medication
current: _____
previous: _____
Have you ever been hospitalized for mental health treatment? Yes No
If so, when? _____
Where? _____

MEDICAL HISTORY

Do you have a primary care doctor? Yes No
Name: _____
Phone: _____ Date of last exam? _____

Do you have allergies? Yes No
If so, please describe _____

Are you having any sleep problems? Yes No
If so, please describe _____

Are you experiencing any current medical problems? Yes No
Any past medical problems? Yes No
If so, please describe _____
_____
_____

ADDITIONAL INFORMATION (optional)

Religion/Spirituality _____
Race/Ethnicity _____
Any other information you would like your therapist to know? _____
_____
_____