Exceptional Minds Counseling, LLC
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Child/Adolescent Name:
Date of birth: *Age:* *Gender:*
Street Address:
City: *State:* *County:* *Zip:*
Home Phone: *Cell Phone:*
Email:
School: *Grade:*
School Contact (Principal/Counselor etc.):
Parent/Guardian Name:
Date of Birth: *Relation to Patient:*
Street Address (If different from patient):
City: *State:* *County:* *Zip:*
Place of Employment: *Occupation:*
Home Phone: *Work Phone:*
Cell Phone: *Email:*
Marital Status:
Other Parent Name:
Date of Birth: *Relation to Patient:*
Street Address (If different from patient):
City: *State:* *County:* *Zip:*
Place of Employment: *Occupation:*
Home Phone: *Work Phone:*
Cell Phone: *Email:*
Marital Status:
Emergency Contact *(Other than parent/guardian):*
Relation to Patient: *Phone #:*
Sliding Fee Assessment/ Must Provide Documentation If Applicable
Approximate Yearly Gross Income:
Number of Dependents claimed on Taxes:

INTAKE INFORMATION
Child/Adolescent Form

Patient Name: _____ DOB: _____ Date: _____
Person(s) who completed this form: _____

Who does the child/adolescent currently live with?

Name	*Relation to Patient*	*Age/DOB*

If different from above, please list family members currently not living with the child/adolescent (include parents, stepparents, siblings (step and ½ siblings).

Name	*Relation to Patient*	*Age/DOB*

Current marital status and marriage history of both parents

Names	*When married/how long*	*Divorced/Separated/Together*

Past Treatment History (Including Drug/Alcohol Treatment): (*Please check the boxes below that apply to the child/adolescent's history and then fill in the chart)*

___ Occupational Therapy ___ Outpatient counseling ___ Inpatient Hospitalization
___Psychological Testing ___ Partial Hospital Program ___Residential Treatment
___Psychiatric Medication ___Support/Counseling Group ___ Drug/Alcohol Treatment

Health Provider or Name of Hospital/Program	*Dates of Treatment*	*Reason for Treatment or Admission*

Family Mental Health History: *Please check yes next to the boxes below if the patient or any family member (including aunts, uncles, grandparents, etc.) have had difficulties with any of the following issues or conditions.*

	Yes	*No*	*Maybe?*	*What family member (s)/Give details*
Depression				
Anxiety Disorder				
Bipolar Disorder				
Schizophrenia				
Hallucinations/Delusions				
Obsessive Compulsive Disorder				
ADHD				
Autism Spectrum/Aspergers				
Intellectual or Learning Disability				
Eating Disorder				
Trauma experience				
Physical and/or Sexual Abuse (victim or perpetrator)				
Alcohol/Drug Abuse or Addiction				
In trouble with the law (arrested, probation, jail)				
Suicide/Suicide Attempts				
Psychiatric Hospitalization				
Other:				
Please use the space to the Right to add more details If needed.				

Developmental History: (*Put N/A if unknown)*

Prenatal care: *_____Normal ____Mother smoked ____Mother used Drugs or Alcohol (please describe below) _____Pregnancy complications (please describe) ____Unknown.*

_____

_____

Birth: *_____ Normal Vaginal Delivery _____ Complications (Please explain below)*

_____

_____

Infancy: *(please check all boxes that apply) _____Happy baby ___Poor sleeper ____Colicky ____Trouble gaining weight ___Milk/Formula/Food allergies ___Other (please use space below to expand on any of the check marked items)*

_____

_____

Developmental Milestones*: Age started walking _____ Any delays in gross or fine motor skills? _____ Age your child was potty trained during the daytime _____ Any Language or speech problems? _____*

_____

_____

History of Physical, Sexual, or Emotional Abuse: *(Please include age(s) the abuse occurred, what happened, who was involved, ever reported to police or children's protective services?)*

_____

_____

_____

_____

_____

Physical Health (Past and Current)

Note: I am not a Physician. For medical problems you need to seek help from your doctor. *Sometimes physical illnesses can cause emotional difficulties, and emotional problems can aggravate physical problems. I have found it helpful to have you answer the following medical questions. Sometimes contact your primary care physician may be beneficial, but this would only happen with your signed authorization.*

Patient's current Primary Care Physician: _____

Name

_____

Street Address *City* *State* *Zip*

_____ _____

Phone Number *Email Address*

When was your child/adolescent last seen by a medical doctor, and for what reason?

_____

_____

Please check if your child or adolescent has ever had any of the following and then provide more details on the lines below:

_____*High blood pressure*
_____*Low blood pressure*
_____*Diabetes*
_____*Asthma*
_____*Cancer*
_____*Sexually Transmitted Disease*
_____*Seizures*
_____*Thyroid Problems*
_____*Bowel/Stomach Disorders*
_____*Chronic Ear Infections/Tubes*
_____*Heart Disease*
_____*Arthritis*
_____*Allergies*
_____*Sight Problems*
_____*Hearing Loss*
_____ *Headaches*
_____*Immune Deficiency Disorder*
_____*Head Injury*
_____*Vitamin Deficiency*
_____*Other health problem*

More information on above checked items*:* _____

_____

_____

_____

Previous hospitalizations/or surgeries*:* _____

_____

_____

_____

_____

_____

_____

<u>Female adolescent patients</u>- *Has the patient ever been pregnant? _____ If yes, how many times? _____*

At what age did the patient start menstruation? _____ Any problems with mood, severe cramping, or irregular cycles?

_____

_____

_____

_____

Has your child adolescent had a Gynecologist? (*If yes, include name/phone #):* _____

_____

Medication/Drug Use History:

Please list below any current prescribed medications the patient or an immediate family member is currently taking.

Name of Medication	*Current Dosage*	*How long?*	*Patient*	*Family Member*

Past Prescribed Psychiatric Medications of patient and/or immediate family:

Name of Medication	*Dosage*	*When/How long?*	*Patient*	*Family Member*

Is your child/adolescent allergic to any medicines or ever have a bad reaction to any medicines?_____

_____

_____

Present and Past Illicit Drug Use of patient and/or immediate family member:

Name of Drug	*How often/How much*	*When*	*Patient*	*Family Member*

To the best of your knowledge, please describe any past or current problems your child/adolescent has had with alcohol and/or drugs or other substances?_____
_____
_____
_____
_____
_____
_____

Please describe any past or current problems the parents or other relatives have had with alcohol or drugs? _____
_____
_____
_____

On average how many cups of caffinated drinks does your child/adolescent drink per day?
_____

To your knowledge, does your child/adolescent smoke cigarettes? _____How much? _____

To your knowledge, has your child been sexually active? _____ If yes, is your child using any form a birth control? _____What kind? _____ Please explain any concerns:_____
_____
_____

Education (History and Current):

Names of schools attended	*What years did they attend?*

***Type of Education attending**: ___Regular ___Special Education ___Vocational ____Home schooled ___Gifted/AP ___Unknown ___Other.*
***Current Grades:** ___Average ___Above Average ___Below Average ___Failing __N/A*
***Past Grades**: ___Average ___Above Average ___Below Average ___Failing.*
***Highest Grade Completed**: _____*

***History of Behavior Problems at School**: ___No ___Yes (explain):*

_____
_____

Legal History (Please describe any current or history of arrests, stays in detention, DUI, probation, Custody issues): (*If patient is a child, please include this information about parents and siblings)*

_____
_____
_____
_____
_____
_____

Current Functioning: *(Please put a check next to the items that apply to your child)*

***Sleep:** ___Trouble falling asleep ___Trouble staying asleep ___Trouble waking up*
___Insomnia ___Excessive Sleep ___Nightmares ___Night terrors ___Sleep Walking
___Irregular sleeping pattern ___ Scared to sleep alone ___None

_____
_____

***Appetite** (In past 3 months*): *___Increase ___Decrease ___ No Change*
Any weight gain or loss? How much? _____
***Abnormalities**: ___Gorging/Binging ___Vomiting ___Fasting ___Laxative Use ___Other*

_____
_____

Relationships:
Describe relationships with friends:

_____
_____

Describe relationship with Siblings:

_____
_____

Describe relationships with Parents:

_____
_____

Describe relationships with teachers/authority

_____
_____

Please describe current involvement in sports, hobbies, clubs, community activities:

_____
_____
_____

Has your child/adolescent ever made a threat, gesture, attempt, or even joked about harming him or herself? *(If yes, please give more detail below)* _____
_____
_____
_____

Has your child/adolescent ever threatened or followed through on physically assaulting or hurting another person? *(Please explain in more detail below):* _____
_____
_____
_____

Do you have any current concerns that your child/adolescent may be at risk for hurting themselves or others? _____
_____
_____
_____

Please describe if there are any religious, cultural, or ethnic influences in the Family that would be beneficial for therapist to be aware of:
_____
_____
_____

Describe at least three strengths or positive qualities about your child/adolescent: _____
_____
_____
_____
_____

Please list at least three improvements you would like to see in your child/adolescent and/or family after coming to therapy:
1.) _____
2.) _____
3.) _____
4.) _____

How long do you estimate it may take to reach the above goals in therapy? *(Please circle)*

1-3 sessions *4-10 sessions* *3-6 months* *6 months- 1 year* *Longer than 1 year*

Do not know *Other:* _____

Please describe any additional information that you think would be important for me to know regarding your child/adolescent: _____

Signature of Guardian that filled out this form:

_____