



Adolescent Intake Form

Identification Information:

Date: _____

Child's Name: _____ Age: _____ DOB: _____

Race: White Black African American American Indian Alaska Native Other: _____

Social Security Number: _____

Child's Primary Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Which best describes you: Employed Disabled Student

School: _____ Grade: _____ Teacher: _____

It is customary NewSong practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail, please provide an alternate mailing address here: _____

Guardian's Name (s): _____

Relationship: _____ Guardian's Contact Phone Number: _____

Email: _____

With whom does the child presently reside? _____

Emergency Contact Information (other than parents/guardian)

Name: _____ Relationship: _____

Phone: _____

I authorize release of information to this emergency contact individual(s) as needed for emergency purposes: yes _____ no _____

Name _____ Date of Birth _____

FATHER

Name: _____ Age: _____ DOB: _____

Race: White Black African American American Indian Alaska Native Other: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: (H) _____ (C) _____ (W) _____

Email: _____ Preferred method of contact: **Phone** or **Email**

Employer: _____ Occupation: _____

Gross Annual Income (before taxes) \$ _____

Marital Status (circle one): **Single Married** (yrs.____) **Divorced Widowed Separated**

Spouse / Significant Other: _____

Age when first married (if married): _____ Age at birth of child: _____

Has the child's father been previously married? **Yes No**

MOTHER

Name: _____ Age: _____ DOB: _____

Race: White Black African American American Indian Alaska Native Other: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: (H) _____ (C) _____ (W) _____

Email: _____ Preferred method of contact: **Phone** or **Email**

Employer: _____ Occupation: _____

Gross Annual Income (before taxes) \$ _____

Marital Status (circle one): **Single Married** (yrs ____) **Divorced Widowed Separated**

Spouse / Significant Other: _____

Age when first married (if married): _____ Age at birth of child: _____

Has the child's mother been previously married? **Yes No**

Name _____ Date of Birth _____

Siblings / Other Household Members:

Name:	Relationship:	Age/Gender:	School/Grade:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What kind of relationship does the client have with his/her siblings? **GOOD FAIR POOR**

What kind of relationship does the mother have with this child? **GOOD FAIR POOR**

What kind of relationship does the father have with this child? **GOOD FAIR POOR**

How did the parents feel when this child was born? _____

How do the parents communicate love to the child? _____

What are the main methods of discipline used at home and how effective have they been?

Has the child ever experienced any type of abuse? (physical/sexual/verbal) If so, please describe: _____

Custody Arrangements: *(if applicable)*

Primary Residential Parent: _____

Visitation Schedule:

Client is with _____ on _____

Client is with _____ on _____

According to the Parenting Plan, who is authorized to make health care decisions? (circle one)

Father Mother Joint Other (please specify): _____

*** Please provide NewSong Counseling Center with a copy of the custody arrangement.**

Name _____ Date of Birth _____

MEDICAL/MENTAL HEALTH INFORMATION:

Medical conditions or illnesses: _____

Accidents or injuries: _____

Hospitalizations: _____

Child's Current Pediatrician: _____

When was your last medical check-up? _____

Is the child currently on any medications? **YES** **NO**

If yes, please list all of the medication(s) he/she is currently taking.

Preferred Pharmacy: _____

Has the child experienced any of the following? (please circle all that apply)

Surgery Asthma High fever Convulsions/seizures eye problems

Allergies Hearing Problems Loss of consciousness Other

Explain Allergies: _____

Explain "other": _____

How would you rate the child's overall health? (please circle)

GOOD 10 9 8 7 6 5 4 3 2 1 POOR

Briefly describe significant family events which the child has experienced: (divorce, remarriage, death, domestic violence)

How does the child interact with family members? _____

Name _____ Date of Birth _____

Please indicate any of the following disorders which any of the client's blood RELATIVES have had by checking the corresponding box:

	Mother	Father	Sister	Brother	Grandfather	Grandmother
ADHD/ADD						
Alcoholism						
Anemia						
Anxiety						
Asthma						
Cancer						
Depression						
Diabetes						
Drug Addiction						
Epilepsy						
Fears/Phobias						
Hepatitis						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Low Blood Pressure						
Manic Depression						
Obsession Compulsion with specific activities						
Psychiatric Treatment						
Stroke						
Venereal Disease						

DEVELOPMENTAL HISTORY:

Please describe the mother's pregnancy: _____

Were there any problems during the pregnancy of this child? YES NO

If yes, please describe: _____

During pregnancy, did the child's mother:

Smoke? YES NO Use alcohol? YES NO

Use street drugs? YES NO If yes, please list: _____

How was/is the child's physical health from 0-12 years? GOOD FAIR POOR

Name _____ Date of Birth _____

Explain anything unusual: _____

How was/is the child's physical development from 0-12 years? **GOOD FAIR POOR**

Explain anything unusual: _____

How was/is the child's emotional development from 0-12 years? **GOOD FAIR POOR**

Explain anything unusual: _____

Circle any of the following which did NOT occur in a typical developmental time period.

Smiled Sat without support Walked alone Spoke first word

Used two- or three-word sentences Completely weaned Started toilet training

Completely toilet trained Completely dressed him/herself

CHILD'S ACADEMIC HISTORY:

Does the child enjoy school? **YES NO**

Does the child have any learning challenges? If yes, please describe: _____

Has the child had any special testing or evaluation? If yes, please describe: _____

List any special services that the child is currently receiving: (tutoring, speech therapy, etc.)

What kind of grades does the child typically receive in school?

ABOVE AVERAGE AVERAGE BELOW AVERAGE

Has the child ever repeated a grade? If yes, specify which grade _____

Is the child involved in extra-curricular activities? (band, sports, etc.) If yes, please describe:

How many close friends does the child have? _____

Name _____ Date of Birth _____

How does the child relate to his/her classmates? **GOOD FAIR POOR UNSURE**

How does the child relate to his/her teachers? **GOOD FAIR POOR UNSURE**

Has the child experienced any of the following problems at school? (please circle all that apply)

Gang influence Incomplete Homework Behavior Problems Poor Attendance

Suspension Exposure to drugs/alcohol Detention Fighting

CHILD'S PRESENT PSYCHOLOGICAL STATUS:

Does the child experience any of the following personal habits? (please circle all that apply.)

Nail-biting Temper tantrums Nightmares Thumb-sucking Bedwetting

Fears Phobias Running away Other

Explain "other": _____

How would you describe the child's personality? _____

Please list the child's hobbies or other interests. _____

Does the child have any pets? If yes, what kind(s)? _____

Is there anything currently bothering the child, causing worry or stress? If yes, please explain?

Has the child ever experienced any serious personal, emotional losses? Please describe.

How would you rate the child' temper? **SHORT MEDIUM LONG**

Has the child ever made statements of want to hurt self or someone else? **YES NO**

Name _____ Date of Birth _____

PRESENTING ISSUES: *Please describe any of the following concerns which the child may have and length of time the issue has been present:*

Behavior _____

Relationships _____

Activities _____

Academics _____

Family Situation _____

Development _____

Habits _____

Gender Confusion _____

Other _____

ADDITIONAL INFORMATION:

Has the child previously been in counseling? **YES** **NO**

If yes — Dates and Provider: _____

Child's response to treatment:

Why are you currently seeking counseling for the child? _____

Who referred you to NewSong Counseling Center? _____

Please tell me anything else that you would like for me to know about the child. (use back of page if needed)

Guardians' Signature: _____ **Date:** _____