Smiling Spirit Pathways
122 N. Salem St. Suite 201N,
Apex, NC 27502

CHILD & ADOLESCENT INTAKE FORM

Please provide the following information by answering the questions below and bring this form to your first session. Please note that the information you provide here is protected as confidential information.

Client's Name: _____
(last) (first) (middle initial)

Name of parent/guardian (if under 18 years):

_____
(last) (first) (middle initial)

Name of person completing form: _____

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status: □Never Married □Domestic Partnership □Married
□Separated □Divorced □Widowed

Please list any children/age: _____

Address: _____
(street and number)

_____
(city) (state) (zip)

Home Phone: (_____) _____-_____ May we leave a message? □ Yes □No
Cell/Other: (_____) _____-_____ May we leave a message? □ Yes □No

Email: _____ May we email you? □ Yes □No
*Please note: Email correspondence is not considered to be a confidential means of communication.

Referred by (if anyone specific): _____

Has the client previously received any type of mental health services (e.g., psychotherapy, counseling, or psychiatric services)? □No □Yes
If yes, previous therapist/practitioner: _____

If you need any more space for any of the following questions, please use the back of the paper.

Primary reason for seeking services:

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□Anger Management □Anxiety □Coping □Depression
□Eating disorder □Fear/Phobias □Mental Confusion □Sexual concerns
□Sleeping Concerns □Addictive behaviors □Alcohol/drugs □Hyperactivity
□Other mental health concerns (please specify): _____
_____

Family History

Parents

With whom does the client live at this time: _____
Are parents divorced or separated: □No □Divorced □Separated
If Yes, who has legal custody? _____
Were the client's parents ever married: □Yes □No
Is there any significant information about the parents' relationship or treatment toward the client which might be beneficial in counseling? □ Yes □ No
If yes, describe: _____
_____

Client's Mother

Name: _____ Age: _____ Occupation: _____ □FT □PT
Place of Employment: _____ Work Phone: _____
Mother's Education: _____
Is the client currently living with mother? □ Yes □ No
□Biological Parent □Step-parent □Adoptive Parent □Foster Parent □Other (specify): _____
If there anything notable, unusual or stressful about client's relationship with the mother?
□ Yes □ No If yes, please describe: _____
_____
How is the client disciplined by the mother? _____
For what reasons is the client typically disciplined? _____

Client's Father

Name: _____ Age: _____ Occupation: _____ □FT □PT
Place of Employment: _____ Work Phone: _____
Father's Education: _____
Is the client currently living with father? □ Yes □ No
□Biological Parent □Step-parent □Adoptive Parent □Foster Parent □Other (specify): _____
If there anything notable, unusual or stressful about client's relationship with the father?
□ Yes □ No If yes, please describe: _____
_____
How is the client disciplined by the father? _____
For what reasons is the client typically disciplined? _____

Client's Siblings and Others Who Live in the Household

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Name of Sibling	Age	Gender	Lives	Quality of relationship with the client
_____	_____	_____	□home □away	□poor □average □good
_____	_____	_____	□home □away	□poor □average □good
_____	_____	_____	□home □away	□poor □average □good
_____	_____	_____	□home □away	□poor □average □good
_____	_____	_____	□home □away	□poor □average □good

Others living in household	Age	Gender	Relationship to client	Quality of relationship
_____	_____	_____	_____	□poor □average □good
_____	_____	_____	_____	□poor □average □good
_____	_____	_____	_____	□poor □average □good
_____	_____	_____	_____	□poor □average □good
_____	_____	_____	_____	□poor □average □good

Comments: _____
_____
_____

Family Health History

Have any of the following diseases occurred among the client's blood relatives (parents, siblings, aunts, uncles, or grandparents)? Check all that apply:

□Allergies □Deafness □Muscular Dystrophy
□Anemia □Diabetes □Nervousness
□Asthma □Glandular problems □Perceptual motor distortion
□Bleeding tendency □Heart disease □Mental Retardation
□Blindness □High blood pressure □Seizures
□Cancer □Kidney disease □Spina Bifida
□Cerebral Palsy □Mental Illness □Suicide
□Cleft Lips □Migraines □Other (specify): _____
□Cleft Palate □Multiple sclerosis _____

Comments regarding family health: _____
_____

Childhood/Adolescent History

Pregnancy/Birth

Has the client's mother had any occurrences of miscarriages or stillborn births? □ Yes □ No
If Yes, please describe: _____
Was the pregnancy with the client planned? □ Yes □ No Length of pregnancy: _____
Mother's age at the client's birth: _____ Father's age at the client's birth: _____
Client: Number _____ of _____ total children

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How many pounds did the mother gain during pregnancy? _____
While pregnant did the mother smoke? □ Yes □ No If Yes, what amount? _____
Did the mother use drugs or alcohol? □ Yes □ No If yes, type/amount: _____
While pregnant did the mother have medical/emotional difficulties? (e.g., surgery, hypertension, medication) □ Yes □ No If Yes, describe: _____
Length of labor: _____ Induced: □ Yes □ No Caesarean section? □ Yes □ No
Baby's birth weight: _____ Baby's birth length: _____
Describe any physical or emotional complications with delivery: _____
_____
Describe any complications for the mother or the baby after the birth: _____
_____
Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood (Check all the apply):

□Breast fed	□Milk Allergies	□Vomiting	□Diarrhea
□Bottle fed	□Rashes	□Colic	□Constipation
□Not cuddly	□Cried often	□Rarely cried	□Overactive
□Resisted solid food	□Trouble sleeping	□Irritable when awakened	□Lethargic

Developmental History (Please note the age at which the following behaviors took place):
Sat alone: _____ Dressed Self: _____
Took 1st steps: _____ Tied shoelaces: _____
Spoke words: _____ Rode two-wheeled bike: _____
Spoke sentences: _____ Toilet trained: _____
Weaned: _____ Dry during the day: _____
Fed self: _____ Dry at night: _____
Compared with others in the family, child's development was: □ slow □ average □ fast
Age for following developments (fill in where applicable):
Began puberty: _____ Menstruation: _____
Voice change: _____ Convulsions: _____
Breast development: _____ Injuries or hospitalizations: _____
Issues that affected client's development (e.g., physical/sexual abuse, inadequate nutrition, neglect):
_____

Education
Current school: _____ School phone number: _____
Type of school: □Public □Private □Homeschool □Other: _____
Current Grade: _____ Teacher: _____ School Counselor: _____
In special education: □ Yes □ No If Yes, describe: _____
In gifted program? □ Yes □ No If Yes, describe: _____
Has the client ever been held back in school? □ Yes □ No If Yes, describe: _____
Which subjects does the client enjoy in school? _____
Which subjects does the client dislike in school? _____
What grades does the client usually receive in school? _____

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Have there been any recent changes in the client's grades? □ Yes □ No If Yes, describe: _____

_____

Has the client been tested psychologically? □ Yes □ No If Yes, describe: _____

_____

Check the descriptions which specifically relate to your child:

Feelings about school work:

□Anxious □Passive □Enthusiastic □Fearful
□Eager □No expression □Bored □Rebellious
□Other (describe): _____

Approach to School Work:

□Organized □Industrious □Responsible □Interested
□Self-directed □No initiative □Refuses □Does only what is expected
□Sloppy □Disorganized □Cooperative □Doesn't complete assignments
□Other (describe): _____

Performance in School (Parent's opinion):

□Satisfactory □Underachiever □Overachiever
□Other: _____

Child's Peer Relationships:

□Spontaneous □Follower □Leader □Difficulty making friends
□Makes friends easily □Long-time friends □Shares easily
□Other (describe): _____

Who handles responsibility for the client in the following areas?
School: □ Client □Mother □Father □ Shared □Other: _____
Health: □ Client □Mother □Father □ Shared □Other: _____
Problem Behavior: □ Client □Mother □Father □ Shared □Other: _____

If the client is involved in a vocational program or works a job, please fill in the following:
What is the client's attitude toward work? □Poor □Average □Good □Excellent
Current employer: _____ Position: _____ Hours per week: _____
How have the client's grades in school been affected since working? □Lower □Higher □ Same
How many previous jobs or placements has the client had? _____
Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercise, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

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_____ _____ _____

Medical/Physical Health

□Abortion
□Asthma
□Blackouts
□Bronchitis
□Cerebral palsy
□Chickenpox
□Congenital problems
□Croup
□Diabetes
□Diphtheria
□Dizziness
□Ear aches
□Ear infections
□Eczema
□Encephalitis
□Fevers
□Hay fever
□Heart trouble
□Hepatitis
□Hives
□Influenza
□Lead poisoning
□Measles
□Meningitis
□Miscarriage
□Multiple sclerosis
□Mumps
□Muscular dystrophy
□Nosebleeds
□Other skin rashes
□Paralysis
□Pleurisy
□Pneumonia
□Polio
□Pregnancy
□Rheumatic fever
□Scarlet fever
□Seizures
□Severe colds
□Severe head injury
□Sexually transmitted disease
□Thyroid disorder
□Vision problems
□Wearing glasses
□Whooping cough
□Other: _____
_____

List any current health concerns: _____
_____

List any recent health or physical changes: _____
_____

Behavioral/Emotional Health

□Affectionate
□Aggressive
□Alcohol problems
□Angry
□Anxiety
□Attachment to dolls
□Avoids adults
□Bedwetting
□Blinking, jerking
□Bizarre behaviors
□Bullies, threatens
□Careless, reckless
□Chest pains
□Clumsy
□Frustrated easily
□Gambling
□Generous
□Hallucinations
□Head banging
□Heart problems
□Hopelessness
□Hurts animals
□Imaginary friends
□Impulsive
□Irritable
□Lazy
□Learning problems
□Lies frequently
□Sad
□Selfish
□Separation anxiety
□Sets fires
□Sexual addiction
□Sexual acting out
□Shares
□Sick often
□Short attention span
□Shy, timid
□Sleeping problems
□Slow-moving
□Soiling
□Speech problems

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□Confident	□Listens to reason	□Steals
□Cooperative	□Loner	□Stomachaches
□Cyber addiction	□Low self-esteem	□Suicidal threats
□Defiant	□Messy	□Suicidal attempts
□Depression	□Moody	□Talks back
□Destructive	□Nightmares	□Teeth grinding
□Difficulty speaking	□Obedient	□Thumb sucking
□Dizziness	□Often sick	□Ticks or twitching
□Drug dependence	□Oppositional	□Unsafe behaviors
□Eating disorder	□Over active	□Unusual thinking
□Enthusiastic	□Overweight	□Weight loss
□Excessive masturbation	□Panic attacks	□Withdrawn
□Expects failure	□Phobias	□Worries excessively
□Fatigue	□Poor appetite	□Other:
□Fearful	□Psychiatric problems	_____
□Frequent injuries	□Quarrels	_____

Please describe any of the above (or other) concerns? _____

_____

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Nutrition

	How often	Typical foods eaten	Typical amount eaten
Breakfast	_____ times/week	_____	□None □Low □Med □High
Lunch	_____ times/week	_____	□None □Low □Med □High
Dinner	_____ times/week	_____	□None □Low □Med □High
Snacks	_____ times/week	_____	□None □Low □Med □High

Comments: _____

Most Recent Examinations

	Date of most recent visit	Results
Physical Exam	_____	_____
Dental Exam	_____	_____
Vision Exam	_____	_____
Hearing Exam	_____	_____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? □ Yes □ No
If Yes, describe: _____
_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes/No	When	Where	Overall experience
Counseling	_____	_____	_____	_____
Psychiatric services	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____
	Yes/No	When	Where	Overall experience
Hospitalizations	_____	_____	_____	_____

Has the child/adolescent experienced death (e.g., friends, family, pets)? □ Yes □ No
At what age? _____ Please describe the child/adolescent's reaction: _____
_____
Have there been any other significant changes or events in your child's life (e.g., family, moving, fire)?
□ Yes □ No If yes, describe _____
_____
Any additional information that you believe would assist us in understanding the client?
_____
_____
_____
Any additional information that would assist us in understanding current concerns or problems?
_____
_____
_____
What are your goals for therapy? _____
_____
What family involvement would you like to see in therapy? _____
_____
Do you believe your child is suicidal at this time? □ Yes □ No

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If yes, explain: _____
_____

For Staff Use:

Therapist's comments: _____
_____
_____
_____
_____

Therapist's signature/credentials: _____ Date: ____/_____/_____