

# Child and Adolescent Intake Form

Thank you for taking the time to complete this form. It helps us get to know your child before the first visit. Please answer as thoroughly as possible. If you're unsure about a question or it doesn't apply, feel free to skip it or write "unsure" or "N/A."

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## Reason for Seeking Services

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What are your main concerns for your child's mental health?

When did you first notice these concerns?

How are these concerns affecting your child at home?

How are these concerns affecting your child at school?

How are these concerns affecting your child's friendships or social life?

What have you tried so far to help? What has worked? What hasn't worked?

## Household and Family Structure

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Marital Status of Parents/Guardians:

- Married
- Partnered
- Separated
- Divorced
- Widowed
- Never married

If separated or divorced, does your child live in two households?

- Yes    No

If yes, please describe the custody arrangement:

Are there any current custody disputes or ongoing legal matters?

- Yes    No

If yes, please describe:

## Household Information

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Who does your child live with? (Please list names, relationships, and ages)

Does your child have any pets? If yes, please list type and name:

## Current Symptoms (Check all that apply)

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Depression:

- Sad or down mood
- Irritability or crankiness
- Loss of interest in things they used to enjoy
- Lack of motivation or not wanting to do things
- Low energy or feeling tired all the time
- Decreased appetite or not feeling hungry
- Weight loss without trying
- Increased appetite or eating more than usual
- Weight gain without trying
- Trouble concentrating or focusing
- Feeling hopeless or like things won't get better
- Low self-esteem or feeling bad about themselves
- Excessive guilt or blaming themselves
- Ongoing sadness about a loss or death
- Thoughts about death or suicide
- Mood gets worse during certain seasons (like winter)
- Other:

Mood Disorder:

- Temper outbursts with yelling or physical actions that are way too big for the situation and don't match their age
- Stays irritable or angry most of the time between outbursts
- At least 4 days of feeling overly confident or thinking they're better than they really are
- At least 4 days of needing much less sleep than usual but still feeling rested (like feeling fine on 3 hours of sleep)
- At least 4 days of talking much more than usual or feeling like they can't stop talking
- At least 4 days of thoughts racing through their mind or jumping from topic to topic
- At least 4 days of being much more distracted than usual
- At least 4 days of being much more active, working on projects, or moving around without being able to sit still
- At least 4 days of doing risky things without thinking about the consequences
- Other:

#### Anxiety:

- Feeling nervous or having general worries
- Unable to control excessive worrying
- Panic attacks (sudden intense fear with physical symptoms like racing heart, shortness of breath, dizziness)
- Anxiety about social situations or being around other people
- Fear of performing in front of others (like presentations or sports)
- Avoiding situations because of fear or anxiety
- Separation anxiety (fear of being away from parents or caregivers)
- Fear of specific things like animals, insects, the dark, storms, heights, blood, or needles
- Excessive worry about school or school performance
- Worry about safety or that something bad will happen
- Physical symptoms from anxiety (stomachaches, headaches, muscle tension, feeling shaky)
- Unable to speak in certain situations (like at school) even though they talk at home
- Other:

#### Obsessive Compulsive Disorder (OCD):

- Repeated unwanted thoughts, urges, or mental images that cause a lot of anxiety or distress
- Repetitive behaviors they feel they have to do (like washing hands, checking locks, touching things in a certain order)
- Mental rituals they feel they have to do (like counting, praying, repeating words silently)
- Preoccupied with perceived flaws in their physical appearance that others don't notice
- Difficulty throwing things away or getting rid of possessions (hoarding)
- Pulls out their own hair (from scalp, eyebrows, eyelashes, or other areas)
- Picks at their skin repeatedly
- Other:

Physical Symptoms Related to Stress or Anxiety:

- Physical symptoms (like pain, fatigue, headaches, stomach problems) that are distressing or disrupt daily life
- Constantly worried that their physical symptoms mean something serious
- High levels of anxiety about their health
- Preoccupied with having or getting a serious illness
- Spends a lot of time and energy focused on health concerns
- Frequent health-related behaviors (like constantly checking their body or wanting to go to the doctor a lot)
- Avoids going to the doctor because they're scared of what might be found or afraid of getting sick from being around other sick people
- Stress or emotions seem to make existing medical problems worse

Physical symptoms that doctors can't explain medically:

- Sudden physical symptoms like weakness, shakiness, trouble moving, or seizure-like episodes that doctors can't explain medically
- Symptoms that come and go or don't match what doctors would expect to see
- Physical symptoms that started after a very stressful event
- Other:

Psychosis (Unusual Thoughts or Perceptions):

- Hearing voices or sounds that others don't hear
- Hearing voices that tell them to do things (command hallucinations)

- Seeing things that others don't see
- Feeling sensations on their skin or body that aren't really there
- Smelling odors that others don't smell
- Strong beliefs that seem unusual or don't match reality (like believing someone is trying to harm them when there's no evidence)
- Paranoid thinking or feeling like people are out to get them
- Believes that others can hear their thoughts or that their thoughts are being broadcasted
- Other:

Behavioral Concerns:

- Explosive temper or severe anger outbursts
- Touchy or easily annoyed
- Holds grudges and stays resentful
- Often refuses to follow rules or listen to adults
- Deliberately annoys or bothers others
- Blames others for their own mistakes or behavior
- Often spiteful or wants to get revenge
- Bullies, threatens, or intimidates others
- Starts physical fights
- Has used a dangerous weapon
- Often cruel to other people
- Has been cruel to animals
- Has stolen from someone face-to-face
- Forced someone into unwanted sexual activity
- Problems understanding or caring about others' feelings
- Running away from home
- Often breaks curfew or stays out too late
- History of setting fires
- Lies frequently
- Other:

Attention and Focus (ADHD):

- Fidgety or squirmy
- Difficulty staying focused on tasks
- Hyperfocuses on interesting or fun activities but can't focus on boring tasks

- Difficulty switching focus from one thing to another
- Trouble staying seated when expected to sit
- Climbs on things or runs around at inappropriate times
- Difficulty doing quiet activities
- Gets easily distracted by sounds, sights, or their own thoughts
- Acts as if driven by a motor or always "on the go"
- Talks excessively
- Acts before thinking or is very impulsive
- Frequently interrupts or blurts things out
- Multiple accidents or injuries from impulsive behavior
- Difficulty waiting their turn
- Frequently loses things or has poor organization
- Makes careless mistakes
- Procrastinates or avoids boring tasks that require focus
- Inconsistently follows through on tasks or instructions
- Easily forgetful in daily activities
- Finds it very difficult to relax or wind down
- Often doesn't seem to be listening when spoken to directly
- These symptoms are interfering with school performance
- These symptoms are interfering with home life or relationships
- Other:

Sleep Concerns:

- Trouble falling asleep
- Waking up during the night
- Nightmares or night terrors
- Sleeping too much
- Not wanting to sleep alone
- Snoring or loud breathing during sleep
- Sleepwalking, sleep talking, or other unusual behaviors during sleep
- Other:

Eating and Appetite:

- Picky eating
- Restricting food or eating very little, leading to low body weight
- Fear of gaining weight or becoming fat

- Concerns about body image or shape
- Episodes of eating large amounts of food in a short time (binge eating)
- Behaviors to prevent weight gain (self-induced vomiting, misuse of laxatives, excessive exercise, fasting)
- Eating non-food items (like dirt, paper, hair, soap, chalk)
- Other:

Gender Dysphoria:

- Distress about their assigned sex at birth
- Strong desire to be another gender
- Preference for clothing or appearance typically associated with another gender
- Uncomfortable with their gender at birth body and physical characteristics
- Significant distress about how others see their gender
- Other:

Tics:

- Repetitive movements they can't easily control (like eye blinking, head jerking, shoulder shrugging, facial grimacing)
- Repetitive sounds or words they can't easily control (like throat clearing, sniffing, grunting, coughing, repeating words or phrases)
- Tics that get worse when stressed or anxious
- Tics that interfere with daily activities or social situations
- Other:

Learning, Speech, and Motor Skills:

- Difficulty learning to read or reading below grade level
- Difficulty with writing or spelling
- Difficulty with math or numbers
- Trouble understanding what they read even if they can read the words
- Delayed speech development or started talking late
- Difficulty pronouncing words or sounds (articulation problems)
- Stuttering or stammering
- Trouble finding the right words or expressing thoughts
- Difficulty understanding spoken language or following directions
- Limited vocabulary for their age

- Clumsy or accident-prone
- Difficulty with balance or coordination
- Trouble with fine motor skills (like buttoning, tying shoes, using utensils, handwriting)
- Trouble with gross motor skills (like running, jumping, catching a ball, riding a bike)
- Other:

#### Neurodivergent:

- Difficulty making or keeping friends
- Prefers to play alone or seems uninterested in other children
- Difficulty understanding social cues (like facial expressions, body language, tone of voice)
- Trouble with back-and-forth conversation or taking turns in conversation
- Limited eye contact or avoids looking at people when talking
- Difficulty understanding or expressing emotions
- Takes things very literally or has trouble understanding jokes or sarcasm
- Repetitive movements (like hand flapping, rocking, spinning)
- Repetitive speech (like repeating words, phrases, or sounds)
- Strong need for routines or sameness, gets very upset with changes
- Intense or unusual interests in specific topics
- Lines up toys or objects in a specific way
- Very sensitive to sounds, lights, textures, or smells
- Seeks out certain sensory experiences (like spinning, touching certain textures, making loud noises)
- Picky eating related to food textures or temperatures
- Uncomfortable with certain clothing textures or tags
- Doesn't seem to notice pain or temperature the way other children do
- Other:

## Trauma History

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This section asks about difficult or traumatic experiences your child may have had. These experiences can affect mental health, and knowing about them helps us provide better care. Please answer as openly as you're comfortable.

Has your child experienced or witnessed any of the following? (Check all that apply)

- Physical abuse
- Emotional or verbal abuse
- Sexual abuse or assault
- Neglect
- Domestic violence in the home
- Bullying (in person or online)
- Death of a parent, sibling, or close family member
- Death of a friend or peer
- Parental divorce or separation
- Placement in foster care
- Serious illness or hospitalization
- Painful medical procedures
- Car accident or other serious accident
- Natural disaster
- Community violence or crime
- Other traumatic event:

If you checked any of the above, please provide additional details if you're comfortable (approximate age, relationship to the person involved, duration, etc.):

Does your child show any of these signs related to traumatic experiences?

- Nightmares or bad dreams about the traumatic event
- Flashbacks or acting as if the traumatic event is happening again
- Getting very upset when reminded of the traumatic event
- Physical reactions when reminded of the trauma (racing heart, sweating, feeling panicky)
- Trying to avoid thinking or talking about the traumatic event
- Avoiding people, places, or activities that remind them of the trauma
- Trouble remembering important parts of the traumatic event
- Negative thoughts about themselves, others, or the world
- Blaming themselves for the traumatic event
- Loss of interest in activities they used to enjoy
- Feeling detached or disconnected from others

- Difficulty feeling positive emotions or feeling emotionally numb
- Irritability or angry outbursts
- Reckless or self-destructive behavior
- Being overly alert or on guard (hypervigilance)
- Being easily startled or jumpy
- Difficulty concentrating
- Trouble sleeping
- Other:

## Safety Assessment

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Has your child ever talked about wanting to die or kill themselves?

- Yes    No

If yes, when was the most recent time?

Has your child ever made a suicide attempt?

- Yes    No

If yes, please describe what happened, when, and what treatment was provided:

Has your child ever intentionally hurt themselves (cutting, burning, hitting, etc.)?

- Yes    No

If yes, please describe:

Has your child ever talked about wanting to hurt someone else?

- Yes  No

If yes, please describe:

Is there access to firearms, medications, or other means in the home?

- Yes  No

If yes, are they secured?

- Yes  No

## Current Medications

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Please list all medications your child is currently taking. Include psychiatric medications, medical medications, over-the-counter medications, vitamins, and supplements. For each, include the name, dose, and how often it's taken.

Does your child take their medications as prescribed?

- Yes  Sometimes  No

If not always, what gets in the way?

Does your child have any allergies to medications?

- Yes  No

If yes, please list the medication and the reaction:

## Prior Psychiatric Medications

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Please list any psychiatric medications your child has taken in the past, even if they didn't work or caused side effects. Include the name, approximate dates, dose if known, and response.

Antidepressants (Prozac, Zoloft, Lexapro, etc.):

Mood Stabilizers (Lithium, Depakote, Lamictal, etc.):

Antipsychotics (Abilify, Risperdal, Seroquel, etc.):

Stimulants (Adderall, Ritalin, Vyvanse, Concerta, etc.):

Non-Stimulants for ADHD (Strattera, Intuniv, Kapvay, etc.):

Anxiety Medications (Hydroxyzine, Buspar, etc.):

Sleep Aids (Melatonin, Trazodone, Clonidine, etc.):

Other Medications:

## Preferred Pharmacy

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If medications are prescribed, please provide your preferred pharmacy information:

Pharmacy Name:

Pharmacy Address:

## Psychiatric History

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Is your child currently seeing a therapist?

- Yes    No

If yes, please provide:

Therapist Name:

Practice or Agency:

How long has your child been seeing this therapist?

Has your child seen other therapists in the past?

- Yes    No

If yes, please list names and approximate dates:

Has your child ever been hospitalized for mental health reasons?

- Yes    No

If yes, please provide dates, hospital name, and reason:

Has your child ever been to the emergency room for a mental health crisis?

- Yes    No

If yes, please describe:

Has your child participated in any of the following programs?

- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Day Treatment
- Residential Treatment
- DBT Program

Other:

If yes, please describe when and where:

Has your child had any psychological or neuropsychological testing?

- Yes    No

If yes, please describe what was tested and what the results showed:

## Developmental History

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Prenatal and Delivery History:

How was the mother's overall health during pregnancy with this child?

- Good    Fair    Poor    Don't know

Did the mother experience any medical problems or complications during pregnancy?

- Yes    No

If yes, please specify:

How old were the parents when this child was born?

Mother's age:

Father's age:

What substances, if any, did the mother use during the course of the pregnancy (including before learning that she was pregnant)?

Alcohol:

- Yes    No

If yes, describe amount and frequency:

Tobacco:

- Yes    No

If yes, describe amount and frequency:

Street Drugs:

- Yes    No

If yes, describe what drugs, amount and frequency:

Prescription Drugs:

- Yes    No

If yes, describe what drugs, amount and frequency:

Was this child born:

- Less than 30 weeks gestation  
 30-35 weeks  
 36-40 weeks (full-term)  
 Over 40 weeks (past due)

Was delivery:

- Normal vaginal delivery  
 Breech  
 Caesarian section (C-section)  
 Forceps or vacuum assisted  
 Induced

What was the child's birth weight?

Were there indications of fetal distress during labor or birth?

- Yes    No

If yes, please specify:

Were there any health complications following birth?

- Yes    No

If yes, please specify:

Was the baby in the NICU after birth?

- Yes    No

If yes, for how long and why?

Postnatal Period and Infancy:

Were there any infancy feeding problems?

- Yes    No

If yes, please specify:

Was this child colicky as an infant?

- Yes    No

If yes, please specify:

Were there infancy sleep pattern difficulties?

- Yes    No

If yes, please specify:

Were there problems with responsiveness or alertness during infancy?

- Yes    No

If yes, please specify:

How easy was this child as a baby?

- Very easy  
 Easy  
 Average  
 Difficult  
 Very difficult

Were there any concerns about this child's attachment to the primary caregiver(s)?

- Yes    No

If yes, please specify:

Early Milestones:

Did your child meet developmental milestones on time (sitting, walking, talking, etc.)?

- Yes    No

If no, please describe any delays:

Were there any early concerns about your child's development or behavior?

- Yes    No

If yes, please describe:

Toddler Period:

As an infant/toddler, how did this child behave with other people?

- More sociable than average
- Average sociability
- More shy than average
- Actively avoided socializing

As an infant/toddler, how insistent was this child when he or she wanted something?

- Very insistent
- Somewhat insistent
- Average
- Passive

As an infant/toddler, how active was this child?

- Very active
- Active
- Average

- Less active
- Very inactive

How would you describe this child's play as an infant/toddler? (Check all that apply)

- Loud
- Quiet
- Interested in playing with others
- Played alone
- Imaginative or make believe
- Repetitive
- Rigid or concrete

Developmental Milestones:

Have you or anyone else ever had concerns about this child's development?

- Yes
- No

If yes, please specify:

## Medical History

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Does your child have a primary care provider?

- Yes
- No

If yes, please provide:

Provider Name:

Clinic Name:

Date of last visit:

Does your child have any current or past medical conditions? (asthma, diabetes, seizures, heart problems, thyroid problems, etc.)

- Yes  No

If yes, please list:

Has your child ever had surgery?

- Yes  No

If yes, please list the type of surgery, age, and reason:

Has your child ever had a head injury or concussion?

- Yes  No

If yes, please describe:

Has your child ever had seizures or been diagnosed with epilepsy?

- Yes  No

If yes, please describe:

## Family History

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**Important:** Please only include biological family members (blood relatives) in this section. Do not include step-parents, step-siblings, adoptive relatives, or relatives by marriage.

Does anyone in your child's biological family have a history of any of the following? Please include the relationship to your child (mother, father, sibling, grandmother, uncle, etc.) and the condition.

Depression:

Anxiety:

Bipolar Disorder:

Schizophrenia or Psychosis:

ADHD:

Autism:

Obsessive-Compulsive Disorder (OCD):

Eating Disorders:

PTSD:

Substance Use Disorder or Addiction:

Suicide or Suicide Attempts:

Other Mental Health Conditions:

Medical Conditions (diabetes, heart disease, thyroid problems, cancer, neurological conditions, etc.):

**Cardiac Family History:**

Please indicate if anyone in your child's biological family (parents, siblings, grandparents, aunts, uncles) has a history of the following heart-related conditions, especially if diagnosed before age 50:

Has anyone in the family had any of the following? (Check all that apply)

- Connective tissue disorders (like Marfan syndrome, Ehlers-Danlos syndrome)
- Cardiomyopathies (heart muscle disease)
- Arrhythmias (irregular heart rhythms)
- Need for pacemaker or defibrillator implantation
- Storage diseases (like Pompe disease, Fabry disease)
- Sudden unexplained death (especially in someone young or during exercise)
- Heart attack (MI) or stroke (CVA) before age 50
- Congenital heart defects (born with heart problems)
- Other premature cardiovascular disease before age 50
- None of the above

If you checked any of the above, please provide details (who in the family, what condition, age at diagnosis):

Does your child have any personal history of cardiac problems?

- Yes
- No

If yes, please describe:

## School History

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School Name:

Current Grade:

How is your child doing in school overall?

Does your child have an IEP (Individualized Education Plan)?

- Yes    No

If yes, for what?

Does your child have a 504 Plan?

- Yes    No

If yes, for what?

Has your child ever been evaluated for special education services?

- Yes    No

If yes, what were the results?

Does your child receive any of the following services at school?

- Speech therapy  
 Occupational therapy  
 Physical therapy  
 Counseling or social work  
 Resource room support  
 Paraprofessional support

Other:

Has your child ever been suspended or expelled?

- Yes    No

If yes, please describe:

## Social and Daily Functioning

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Does your child have close friends?

- Yes    No

If yes, how many close friends would you say they have?

How does your child get along with peers overall?

What does your child enjoy doing for fun?

What are your child's strengths? What do they do well?

Is your child involved in any activities? (sports, clubs, music, art, etc.)

How much time does your child spend on screens each day? (TV, phone, tablet, gaming, etc.)

Do you have concerns about your child's screen time or online activity?

- Yes    No

If yes, please describe:

Does your child have any regular responsibilities or chores at home?

How does your child typically handle frustration or disappointment?

## Legal History

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Has your child ever had legal involvement? (arrests, probation, court-ordered services, etc.)

Yes  No

If yes, please describe:

## Substance Use History

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Has your child ever used alcohol, tobacco, nicotine, vaping products, marijuana, or other drugs?

Yes  No

*If you answered no, you may skip the rest of this section.*

Has your child ever used alcohol?

Yes  No

If yes, please describe how much, how often, and when they last used:

Has your child ever used tobacco, nicotine, or vaping products?

- Yes    No

If yes, please describe:

Has your child ever used marijuana or THC products?

- Yes    No

If yes, please describe:

Has your child ever used other drugs (cocaine, methamphetamine, hallucinogens, prescription drugs not prescribed to them, etc.)?

- Yes    No

If yes, please describe:

Have you had concerns about your child's substance use?

- Yes    No

If yes, please describe:

Has your child ever received treatment for substance use?

- Yes    No

If yes, please describe:

### Additional Information

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Is there anything else you'd like us to know about your child that we haven't asked about?

What are your goals for treatment? What would you like to see improve?