Michelle Robinson, MA, LPC
42450 Garfield, Suite B
Clinton Township, MI 48038
586-202-0347

Child-Adolescent Intake Form

(Parents Complete Form)

Please provide the following information about your child:

Childs Full Name:_____

Nick Name:_____

Birth Date: _____ Today's Date _____

Why are you bringing your child for counseling?

_____
_____
_____

What are your treatment goals?

_____
_____
_____

How is this affecting you and your family?

_____
_____
_____

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet?_____
_____
_____

Please provide the following information about your child:

Family History:
The name of the child's biological parents:

Mother:_____ Father:_____

Who has legal guardianship of your child? _____

Who are the people living in the home with your child?

Names	**Ages**	**Relationship to child**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe any past counseling that either your child or any family member has had.

_____
_____

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____

SYMPTOM CHECKLIST

PLEASE CHECK ALL THAT APPLY:

*Parents, if possible, please allow your child to complete this form. If your child is too young, complete symptom check list from your observations of your child.

	Headaches		Memory problems		Depression
	Sleep problems		Heart palpitations		Feeling tense or nervous
	Academic concerns		Ideas of harming yourself		Drug use
	Worries about money		Feeling shy around others		Not confident
	Having a lack of friends		Stomach problems		Concerned about eating habits
	Feelings of panic, fear, phobias		Trouble concentrating		Alcohol use
	Feeling sad or depressed		Grief or loss		Nightmares
	Feeling restless		Feelings of hopelessness		Feelings of worthlessness
	Low self-esteem		Disturbing thoughts		Hallucinations
	Aggression		Mood swings		Recurring thoughts
	Chest pain		Suicidal thoughts		Trembling
	Sexual concerns		Sexual identity concerns		Anger
	Ideas of harming others		Gender Identity		Chronic pain
	Blaming or criticizing self		Abusing others		Dizziness
	Feeling tired		Feeling a need to be on the go		Problems at home
	Anxiety		Antisocial or illegal behavior		Concerned about family members
	Irritability		Abused by others		Sick often
	Isolating self		Disorganized thoughts		Relationship problems
	Distractibility		Impulsive		Poor judgment

Education History:

What school does your child attend? _____

Address:_____

Phone:_____ Teachers Name:_____

Current Grade:_____

How does your child do in school?

_____

_____

Has your child ever repeated a grade? If so which one(s)_____

Has your child ever received special education services?_____

Has your child experienced any of the following problems at school?

	Fighting		lack of friends		drug/alcohol
	Suspension		learning disabilities		poor attendance
	Gang influence		incomplete homework		behavior problems
	detention		poor grades		Other

Medical History:

What is the name of your child's medical doctor?_____

Address: _____ Phone:_____

Date of your child's last medical examination:_____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? _____

Did the child's mother have any problems during the pregnancy or at delivery? If so, Please describe them._____

_____

_____

Has your child experienced any of the following medical problems?

	A serious accident		Hospitalization		Surgery
	A head injury		High fever		Convulsions/seizures

	Eye/ear problems		Meningitis		Hearing problems
	Allergies		Loss of consciousness		Asthma

Please list any medications your child takes on a regular basis:

_____
_____

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal)?

_____
_____

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

_____
_____

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)?

_____
_____
_____

Finally, what are some of the things that are currently stressful to your child and his/her family?_____
_____
_____