Ashley Mullica, MSW, LCSW

CHILD/ADOLESCENT INTAKE FORM

To be completed by a parent/legal guardian. Please bring to your child's first session. Please note that the information you provide here is protected as confidential.

Child's Name:_____
Last First Middle Initial

Date of Birth:_____/_____/_____ **Age:**_____ **Gender:**_____

Parent/Legal Guardian:_____

Address:_____
Number Street City State Zip

Home Phone:_____ **Okay to leave a voicemail? Y N**

Cell Phone:_____ **Okay to leave a voicemail? Y N**

Email:_____ **Okay to email you? Y N**
***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Preferred method of contact: Cell Phone Home Phone Email Text

Other involved adult:_____ **Relationship:**_____

Please circle the issue(s) for which you are seeking treatment:

Behavior at Home	**Behavior at School**	**Hyperactive**
Trauma/PTSD	**Moodiness**	**Family Problems**
Grief/Loss	**Loneliness**	**Eating**
Anxiety/Worry	**Self-Esteem**	**Anger**
Depression	**Physical (ill/tired)**	**Concentration**
Alcohol	**Drugs**	**Sexual Activity**
Social Problems	**Stealing**	**Running Away**

Please explain:_____

_____

_____

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How much has this problem affected your child's life? (Please circle the best answer)

1	2	3	4	5	6	7	8	9	10
Very Little									A Great Deal

Has your child received any type of mental health treatment for this problem (psychotherapy, psychiatric services, etc)? Y N

If yes, previous therapist/practitioner:_____

What was effective about this treatment?_____

_____

What was ineffective about this treatment?_____

_____

What have you tried to solve this problem?_____

_____

Is your child currently taking any prescription medication? Y N

Please list:_____

_____

Has your child ever been prescribed psychiatric medication? Y N

Please list and provide dates:_____

_____

Has your child had any previous psychological treatment or psychiatric hospitalizations for any other problems? Y N

If yes, when, where and for what reason:_____

_____

Any history of cutting? Y N

If yes, please provide details: _____

_____

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GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child's current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Excellent

Please list any health problems for your child:_____

_____

2. How would you rate your child's current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Excellent

Please list any specific sleep problems your child is currently experiencing:

_____

4. Please list any concerns with your child's appetite or eating patterns:

_____

5. Is your child currently experiencing sadness, grief or depression? Y N

If yes, please explain and for how long?_____

_____

6. Is your child currently experiencing anxiety, panic attacks, or phobias? Y N

If yes, please explain and for how long?_____

_____

8. Does your child use alcohol or drugs? Y N

If yes, please provide the drug type, amount and frequency):

_____

9. Has your child ever been treated for alcohol or drug use? Y N

If yes, please provide substance(s), treatment provider(s) and dates:

_____

10. What significant life changes or stressful events has your child experienced:

_____

_____

_____

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FAMILY OF ORIGIN INFORMATION

1. Are the child's parents together? Y N

If not, what are the custody arrangements?_____

_____

2. Has the child always lived with you?_____

3. Does the child have siblings? Y N

If yes, names and ages:_____

SCHOOL INFORMATION

1. Current School:_____ **Current Grade:**_____

2. Does your child receive any special services? Y N

If yes, please list:_____

3. Are there any concerns regarding school behavior or performance?_____

_____

_____

_____

4. How does your child get along with peers/friends?_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to <u>your child</u> in the space provided (father, mother, grandmother, uncle, etc).

	Please Circle		Family Member
Alcohol/Substance Abuse	**Y**	**N**	
Anxiety	**Y**	**N**	
Panic Attacks/Phobias	**Y**	**N**	
Depression	**Y**	**N**	
Eating Disorder	**Y**	**N**	
Bipolar Disorder	**Y**	**N**	
Schizophrenia	**Y**	**N**	
Suicide Attempts	**Y**	**N**	
Obsessive Compulsive Behavior	**Y**	**N**	
Domestic Violence	**Y**	**N**	
Abuse	**Y**	**N**	

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BEHAVIOR CHECKLIST

	Please Circle		Comments
My child sleeps well	**Y**	**N**	
My child has meaningful friendships	**Y**	**N**	
My child is engaged with school	**Y**	**N**	
My child participates in extracurricular activities	**Y**	**N**	
My child displays acts of self-harm	**Y**	**N**	
My child can be aggressive towards peers	**Y**	**N**	
My child can be aggressive towards adults	**Y**	**N**	
My child argues a lot	**Y**	**N**	
My child has excessive fears	**Y**	**N**	
My child often has physical aches/pains	**Y**	**N**	
My child responds well to discipline	**Y**	**N**	
My child appears nervous	**Y**	**N**	
My child lies to avoid responsibility	**Y**	**N**	
My child takes things that are not his/hers	**Y**	**N**	
My child struggles with maintaining attention	**Y**	**N**	
My child shows interest in learning new things	**Y**	**N**	

ADDITIONAL INFORMATION

1. Is your child/family spiritual or religious? Y N

If yes, describe your faith or belief:

_____

2. What do you consider to be some of your child's strengths?

_____

_____

_____

_____

3. What do you consider to be some of your child's weaknesses?

_____

_____

_____

_____

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4. What activities/interests does your child have?

_____

_____

_____

_____

5. What do you hope your child will achieve in therapy?

_____

_____

_____

_____

6. Is there anything else you would like for me to know?

_____

_____

_____

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