



Child/Adolescent Intake Form

Identifying Information

Client Name: _____ DOB: _____ Age: _____

Primary Language: _____ Ethnicity: _____

School: _____ Grade: _____

Parent's Name: _____ Phone #: _____

Address: _____

Parent's Name: _____ Phone #: _____

Address: _____

Legal Guardian/: _____ Phone #: _____

Foster Parent's Name

Address: _____

Ward or Dependent of Court: _____

Reason Referred:

(current primary
symptoms and behaviors,
onset and duration,
history of presenting
problem)

Prior Mental Health History:

(suicidality/homocidality,
medication,
interventions,
response to treatment,
family history)

Legal History/Substance Abuse History:

(child custody,
DCFS involvement,
placements,
family history of legal or
alcohol/drug use)

Medical History:

Pediatrician Name: _____ Phone: _____
Last Exam: _____ Glasses: Yes No Braces: Yes No

(illness, allergies,
accidents,
head injuries, seizures,
pregnancies, STDs,
vaccinations, surgeries,
hearing/vision, dental)

School History:

(academic performance,
attitude/behavior,
strengths/weaknesses,
suspensions,
attendance)

Developmental History:

Prenatal Care: _____ Term/Months: _____ Birth Weight: _____
Any major stressors during pregnancy: _____

Developmental Milestones/Environmental Stressors:

Infancy (Birth-3):
Early Years (4-6):
Latency (6-11):
Adolescence (12+):

Relevant Family History and Current Living Situation:

(family composition,
family relationships,
family strengths)
