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CHILD AND ADOLESCENT INTAKE FORM: ASSESSMENT

To be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand you child. It, as all communications with your therapist, will be kept confidential to the full extent of Washington, DC law.

Today's date _____

BACKGROUND INFORMATION

Child's Name _____ Date of Birth _____ Age _____

Child lives with (✓ one): both biological parents _____ mother _____ father _____

mother & stepfather _____ father & stepmother _____ other _____

If parents are divorced, describe custody arrangements: _____

_____

Child's Address/City/St/Zip _____

_____ Child's Home Phone _____

Emergency Contact Person (other than parent)_____ Phone Number _____

INFORMATION ABOUT CHILD'S MOTHER

Mother's Name _____ Age _____ Race _____

Employer _____ Occupation _____

Home address (if different than above): _____

Mother's home phone (if different than above): _____ Mother's cell phone: _____

Mother's email: _____ May I use this email? ___ yes ___ no

Describe any current or past psychological problems that are important for me to know: _____

_____

Do you have any current or past history of receiving psychotherapy and/or psychiatric medications? ___ yes ___ no

If yes, please describe: _____

_____

INFORMATION ABOUT CHILD'S FATHER

Father's Name _____ Age _____ Race _____

Employer _____ Occupation _____

Address (if different than above): _____

Father's home phone (if different than above): _____ Father's cell phone: _____

Father's email: _____ May I use this email? ___ yes ___ no

Describe any current or past psychological problems that are important for me to know: _____

_____

Do you have any current or past history of receiving psychotherapy and/or psychiatric medications? ___ yes ___ no

If yes, please describe: _____

_____

FAMILY MEMBERS

List all members of your immediate family:

Name	Relationship to Child	Age	Living in House? (Y/N)	Psychological Difficulties

DESCRIBE THE MAIN PROBLEM THAT LEADS YOU TO SEEK SERVICES FOR YOUR CHILD:

What have you already tried to correct or resolve this problem?

Describe the dates and results of prior assessments:

What questions do you hope this assessment will answer / in what ways do you hope this assessment will help your child?

ACADEMIC / SCHOOL INFORMATION

School Name _____ Grade _____ Teacher _____

Has child ever repeated a grade? ___Yes ___No If so, when? _____

Describe your child's academic performance: _____

Describe any academic accommodations: _____

How does your child get along at school? _____

SOCIAL INFORMATION

Describes your child's relationship with peers: _____

_____

Describe what your child likes to do for fun, special interests, hobbies, etc. _____

_____

Describe your child's strengths and positive traits: _____

_____

DEVELOPMENTAL HISTORY

Describe any complications during your pregnancy with and birth of this child: _____

_____

_____

Describe any concerns with your child's development as an infant and toddler: _____

_____

_____

Describe any delays in reaching developmental milestones (walking, talking, toilet training): _____

_____

_____

MEDICAL HISTORY

Describe any major sicknesses, operations, and/or injuries that are important for me to know:

_____

_____

Describe any history of head injury, being knocked unconscious, seizures, unusual staring spells:

_____

_____

Does your child currently take medication for an illness? ___Yes ___No

If yes, please describe: _____