

# Center Point

## Child-Adolescent Intake Form

The following form will become part of your child's confidential record. Please answer each question as completely and as carefully as you can.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Street Address: \_\_\_\_\_ City & State: \_\_\_\_\_ Zip: \_\_\_\_\_

Grade in School: \_\_\_\_\_ School/daycare Attending: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

**May we contact you and leave messages on your...?**

Parent Cell Phone: \_\_\_\_\_  Home Phone: \_\_\_\_\_

Parent Email: \_\_\_\_\_

**You are agreeing to the contacts indicated on this form as a means of contact by signing below:**

\_\_\_\_\_  
Signature (parent/guardian) (Date)

Personal Information

Who referred you to our office? \_\_\_\_\_

May we send them a letter of thanks? Yes  No

Describe any physical problems your child has that require medication or physical care: \_\_\_\_\_

How long ago was your child's last physical? \_\_\_\_\_

Is your child currently receiving medical treatment? Yes  No

If yes, please explain: \_\_\_\_\_

Is your child currently taking any prescription medications? Yes  No

If yes, please list: \_\_\_\_\_

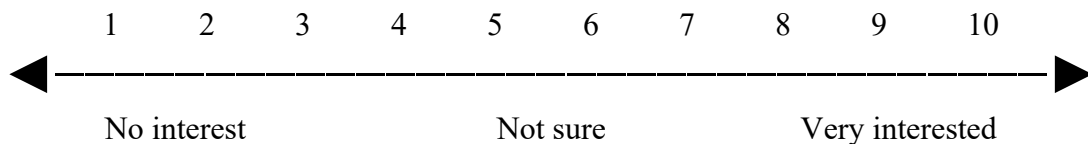
Any family psychiatric history (e.g., depression, anxiety, substance abuse)? Yes  No

If yes, please explain: \_\_\_\_\_

SPIRITUAL BACKGROUND (Optional)

Is your child a part of a local faith community? Yes  No  If so, which one? \_\_\_\_\_

How would you rate your child's current interest in spiritual growth at this time?



Problem Areas

Place a check mark next to each item that identifies an area of concern to your child. Place two checks next to those that are most important. Feel free to add additional comments.

- |   |  |
|---|--|
| <input type="checkbox"/> My child has no problems or concerns   | <input type="checkbox"/> Fears, phobias, suspiciousness                  |
| <input type="checkbox"/> Abuse-physical, sexual, emotional, neglect (of children or elderly)                        | <input type="checkbox"/> Fatigue, tiredness, low energy                  |
| <input type="checkbox"/> Aggression, violence, threats  | <input type="checkbox"/> Failure   |
| <input type="checkbox"/> Alcohol use  | <input type="checkbox"/> Emptiness                                       |
| <input type="checkbox"/> Anxiety, nervousness, panic, tension   | <input type="checkbox"/> Guilt   |
| <input type="checkbox"/> Anger / Frustration, hostility, arguing, irritability, temper problems, self-control       | <input type="checkbox"/> Sleep disturbances-too much/little, insomnia    |
| <input type="checkbox"/> Goals, choices, school   | <input type="checkbox"/> Irresponsibility                                |
| <input type="checkbox"/> Codependence   | <input type="checkbox"/> Thoughts of hurting self                        |
| <input type="checkbox"/> Confusion, thought disorganization   | <input type="checkbox"/> Thoughts of hurting others                      |
| <input type="checkbox"/> Depression, low mood, sadness, crying  | <input type="checkbox"/> Isolation / withdrawal                          |
| <input type="checkbox"/> Education  | <input type="checkbox"/> Thoughts of suicide                             |
| <input type="checkbox"/> Eating difficulties-overeating, under eating, appetite disturbance, vomiting, weight, diet | <input type="checkbox"/> Drug use-prescription, over-the-counter, street |
| <input type="checkbox"/> Fearfulness  | <input type="checkbox"/> Use of alcohol by family member / other         |
| <input type="checkbox"/> Nervousness  | <input type="checkbox"/> Unpleasant thoughts won't go away               |
| <input type="checkbox"/> Memory problems  | <input type="checkbox"/> Obsessive / compulsive behavior, compulsions    |
| <input type="checkbox"/> Physical problems, health, illness   | <input type="checkbox"/> Easily agitated / annoyed                       |
| <input type="checkbox"/> Social relationships, interpersonal conflicts  | <input type="checkbox"/> Loneliness                                      |
| <input type="checkbox"/> Impulsiveness, lack of control   | <input type="checkbox"/> Fatigue   |
| <input type="checkbox"/> Grieving, mourning, deaths, losses, divorce  | <input type="checkbox"/> Difficulty trusting                             |
| <input type="checkbox"/> Judgment problems, risk taking   | <input type="checkbox"/> Trauma  |
| <input type="checkbox"/> Legal matters  | <input type="checkbox"/> Sadness   |
| <input type="checkbox"/> Problems with parents  | <input type="checkbox"/> Stress, tension                                 |
| <input type="checkbox"/> Low energy, lack of motivation   | <input type="checkbox"/> Heart pounding / racing                         |
| <input type="checkbox"/> Low self-esteem, inferiority feelings  | <input type="checkbox"/> Chest pain                                      |
| <input type="checkbox"/> Poor concentration, attention, distractibility   | <input type="checkbox"/> Trembling / shaking                             |
| <input type="checkbox"/> Hopelessness   | <input type="checkbox"/> Friendships                                     |
| <input type="checkbox"/> Worthlessness  | <input type="checkbox"/> Menstrual problems, PMS                         |
| <input type="checkbox"/> Perfectionism  | <input type="checkbox"/> Mood swings                                     |
| <input type="checkbox"/> Oversensitivity to rejection/criticism, shyness  |  |
| <input type="checkbox"/> Headaches, other kinds of pains  |  |

Other: \_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* By signing here, I am consenting to allow this information to become a part of my child's clinical record and understand that it will be maintained in confidence by Center Point.