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 ❑

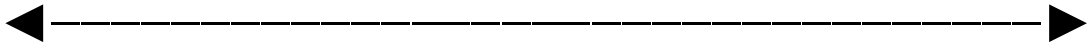
If yes, please explain:_____

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?

1 2 3 4 5 6 7 8 9 10



No interest Not sure Very interested

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.

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

*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.