



WHITE OAK Counseling and Recovery

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CHILD/ADOLESCENT INTAKE FORM

(Age 17 or under)

Dear Parent/Guardian: To help your clinician understand and help your child/adolescent, please answer the questions on this form and bring it with you to his/her first appointment.

Child/Adolescent's Legal Name: _____ Male Female DOB: _____

Forms completed by: _____ Relationship to child/adolescent: _____

Is this child/adolescent adopted? Yes No

Describe his/her best characteristics: _____

RACE/ETHNICITY (optional)

Please check the box that best represents your child/adolescent's race/ethnic background:

African-American/Black Arab American Asian or Pacific Islander Hispanic Multi-racial Native American
 White/Caucasian Other: _____ or check all that apply

PRESENTING PROBLEM/REASON FOR TREATMENT

What is the primary reason for having your child/adolescent seen for counseling?

DSM-5 Parent/Guardian – Rated Level 1 Cross-Cutting Symptom Measure – Child/Adolescent

	During the past TWO (2) WEEKS , how much (or how often) has your child/adolescent... <i>(circle appropriate answer, 0-4)</i>	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Complained of stomachaches, headaches, or other aches and pains?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	2. Said he/she was worried about his/her health or about getting sick?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
II.	3. Had problems sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
III.	4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	5. Had less fun doing things than he/she used to?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
IV.	6. Seemed sad or depressed for several hours?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	7. Seemed more irritated or easily annoyed than usual?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	8. Seemed angry or lost his/her temper?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
V.	9. Started lots more projects than usual or did more risky things than usual?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	10. Slept less than usual for him/her, but still had lots of energy?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
VI.	11. Said he/she felt nervous, anxious, or scared?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
VII.	12. Not been able to stop worrying?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	13. Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	

	During the past TWO (2) WEEKS , how much (or how often) has your child/adolescent... <i>(circle appropriate answer, 0-4)</i>	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
VIII.	14. Said that he/she heard voices – when there was no one there – speaking about him/her or telling him/her what to do or saying bad things to him/her?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
IX.	15. Said that he/she had a vision when he/she was completely awake – that is, saw something or someone that no one else could see?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
X.	16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned on?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
XI.	18. Seemed to worry a lot about things he/she touched being dirty or having germs or be poisoned?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
XII.	19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	In the past TWO (2) WEEKS , has your child/adolescent...	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
XIII.	20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	21. Smoked a cigarette, a cigar, or pipe, used snuff or chewing tobacco?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	22. Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Vallium], or steroids)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	24. In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	25. Has he/she EVER attempted to kill himself/herself?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	

Are there other concerns (not listed above) that you want to discuss?

How have these concerns impacted your child/adolescent's daily life?

YOUR CHILD/ADOLESCENT'S FAMILY AND SUPPORTIVE RELATIONSHIPS

Are parents divorced or separated? No Yes

If yes, how long? _____

What are the current custody/visitation arrangements?

Please tell us about the household/family which your child/adolescent spends the majority of his/her time (or who currently lives with your child/adolescent). List primary household information first, and then list other living situations/supportive relationships:

Name	Age	Relationship (e.g. Father, Mother, Brother, Sister, Step-Sibling, Aunt, Uncle)	Quality of Relationship?	Living with you?
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No

YOUR CHILD/ADOLESCENT'S LIFE STORY

Where does your child/adolescent attend school? _____

What is the highest grade level of school he/she has completed? _____

What have been his/her usual report card grades? _____

Has he/she experienced any of the following in school?

- Learning Problems Discipline Problems Social Problems Emotional Problems

Has there been any academic (IEP) or psychological testing done at school or elsewhere? No Yes

If yes, when? _____

Results: _____

Has your child/adolescent ever received previous counseling, therapy, or psychiatric treatment? No Yes

If yes, with whom? _____

Has your child/adolescent ever been the victim of abuse or neglect? No Yes

If yes, was the abuse: Physical Sexual Emotional Neglect Verbal

Please list any contacts your child/adolescent has had with the courts (including Friend of the Court):

Please list any contacts your child/adolescent has had with the police or Child Protective Services:

Has your child/adolescent ever had a problem with alcohol or other drugs? No Yes

If yes, please explain:

What is your family's current religious affiliation? _____

Describe family involvement: _____

MEDICAL HISTORY

Does your child/adolescent have any current medical concerns?

Has he/she had any past surgical procedures? No Yes

If yes, list: _____

Has he/she been exposed to any contagious diseases, such as Tuberculosis? No Yes

If yes, to what and when did the exposure take place? _____

Are immunizations current? No Yes

Please list all current medications and/or supplements your child/adolescent is currently taking:

(Attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

List any emergency room visits (age, reason): _____

FAMILY MEDICAL HISTORY

Were there any complications with the pregnancy of this child/adolescent that might have impacted his/her prenatal health or development (e.g.: mother had significant illness, smoked cigarettes, drank alcohol, experienced severe bleeding, etc.)?

No Yes

Were there significant problems with his/her health or development in the first few years of his/her life (e.g.: needed to be revived at birth, failure to thrive, or missed significant developmental milestones)? No Yes

If yes, please explain: _____

Biological Father's Name: _____ Age: _____ Education: _____

Occupation: _____ Deceased? No Yes (If yes, when? _____)

Description of relationship between father and child/adolescent: _____

Biological Mother's Name: _____ Age: _____ Education: _____

Occupation: _____ Deceased? No Yes (If yes, when? _____)

Description of relationship between mother and child/adolescent: _____

Has anyone in your child/adolescent's extended family (e.g., parent, grandparent, uncle/aunt) had a psychiatric illness?

No Yes If yes, please describe to the best of your ability (who, symptoms/diagnosis, were they hospitalized?)

Has anyone in your child/adolescent's family attempted suicide? No Yes If yes, who? _____

Has anyone in your child/adolescent's family had a problem with, or been treated for, substance abuse problems?

No Yes If yes, who? _____

Feel free to list any additional information you feel may be helpful to the clinician who will be working with your child/adolescent:

Completed by: _____
(Please sign your name)

Date: _____