Hoxworth Counseling Services
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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… *(circle appropriate answer, 0-4)*	**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?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	2. Said he/she was worried about his/her health or about getting sick?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
II.	3. Had problems sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 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?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	5. Had less fun doing things than he/she used to?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IV.	6. Seemed sad or depressed for several hours?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	7. Seemed more irritated or easily annoyed than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	8. Seemed angry or lost his/her temper?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
V.	9. Started lots more projects than usual or did more risky things than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	10. Slept less than usual for him/her, but still had lots of energy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VI.	11. Said he/she felt nervous, anxious, or scared?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VII.	12. Not been able to stop worrying?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	13. Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

	During the past **TWO (2) WEEKS**, how much (or how often) has your child/adolescent… *(circle appropriate answer, 0-4)*	**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?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 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?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 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?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 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?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
XI.	18. Seemed to worry a lot about things he/she touched being dirty or having germs or be poisoned?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 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?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	In the past **TWO (2) WEEKS**, has your child/adolescent…	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
XIII.	20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	21. Smoked a cigarette, a cigar, or pipe, used snuff or chewing tobacco?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 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)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 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 Vallum], or steroids)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	24. In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	25. Has he/she EVER attempted to kill himself/herself?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 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?
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ 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: _____ Date: _____

(Please sign your name)

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