



Tel 320-257-1800 Fax 320-257-1801 818 2nd Street South, Suite 180 Waite Park, MN 56387 www.granitecitycounseling.com

DATE _____

CHILD/ADOLESCENT CLINICAL INTAKE

(THIS FORM WILL NEED TO BE COMPLETED AND RETURNED AT THE TIME OF YOUR FIRST APPOINTMENT.)

In order for us to be able to fully evaluate your child, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to; do the best you can. Thank you.

PATIENT IDENTIFICATION

Name _____
Birth Date _____ Age _____ Sex _____
Race _____
Address _____
City _____ State _____ Zip _____
Home Phone # _____ Parent's work # _____ (specify mom or dad)
Cell Phone # _____ (specify mom or dad)
Who is the child/teen currently living with? _____
Address of other parent _____
City _____ State _____ Zip _____
Legal Guardians: _____
Name of person completing this form _____

Emergency Information

In case of emergency, contact:
Name: _____ Relationship _____ Phone _____

It is your responsibility to inform Granite City Counseling of changes in address, phone #, insurance coverage.

In an effort to coordinate care, we would like to obtain/give information from previous providers and/or your referral source. **With your written authorization, we will be informing your child's physician (by letter) of his/her diagnosis and care here, communicating (as necessary) with the referring agent and requesting past mental health records.**

Do you wish to sign an authorization for release of information for the following?

Physician's Name: _____ Yes No
Past Mental Health Agency/Counselor: _____ Yes No

REFERRAL SOURCE

Referral Source _____ Phone # _____

REASONS FOR THERAPY

Primary reason for seeking therapy: _____

How long have these problems been developing? _____

Has therapy been discussed prior to the appointment? Circle: Yes No
If yes, what was the child/teen’s reaction? _____

GOALS

What are the goals for your child’s therapy? _____

SYMPTOM CHECKLIST

Please rate the symptoms your child/teen is currently experiencing using the following scale:

0 – never; **1** – mild; **2** – moderate; **3** – severe

Group A

- Seems sad or unhappy
- Suicidal comments
- Self-abusive behavior
- Has trouble falling or staying asleep
- Sleeps too much
- Poor appetite
- Increased appetite
- Significant weight gain
- Significant weight loss
- Talks about feeling stupid or worthless
- Loses interest in having fun
- Seems irritable
- Moody
- Has low energy
- Often plays alone/avoids others
- Cries easily/frequently
- Poor concentration
- Grades have dropped
- Memory impaired
- Loneliness
- Low self-esteem
- Evidence of frequent anger
- Decreased need for sleep
- More talkative than usual
- Restlessness
- Moving slowly
- Feeling agitated
- Feeling hopeless
- Low motivation

Group B

- Physical problems like headaches, stomachaches, dizziness, nausea, loose stools, shakiness
- Excessive worry
- Lacks confidence in abilities
- Needs lot of reassurance
- Needs to be perfect
- Seems fearful and anxious
- Seems shy or timid
- Easily embarrassed
- Sensitive to criticism
- Bites fingernails
- Has nervous habit
- Nightmares/disturbing dreams
- Has fears and phobias
- School refusal
- Difficulty separating from parent
- Excessive checking, counting, washing, cleaning, organizing, evening things out
- Doesn’t sleep in own bed
- Problems with sleep
- Muscle tension
- Restless/keyed up
- Pounding/racing heart
- Sweating
- Trembling
- Trouble breathing
- Chills/hot flushes
- Numbness
- Feeling of choking
- Chest pain
- Nausea/abdominal distress
- Feeling dizzy
- Fear of losing control

Group C

- Always on the go
- Can't sit still
- Doesn't seem to listen
- Often fails to finish things
- Has difficulty keeping attention in tasks or play activities
- Often loses things necessary for tasks or activities (school assignments, pencils, books)
- Often fidgets with hands/feet or squirms in seat
- Easily distracted
- Has a hard time playing quietly
- Talks excessively
- Often interrupts or "butts in" to others' games
- Seems disorganized, loses things needed for school
- Takes risks without considering the danger involved (i.e. running into the street without looking)
- Blurts out answers to questions before they have been completed
- Often has difficulty awaiting turn
- Often leaves seat in situations in which remaining seated is expected
- Is often forgetful in daily activities
- Makes careless mistakes on schoolwork or other activities/fails to pay attention to details
- Often does not follow through on instructions and fails to finish school work, chores or duties
- Avoids activities that require sustained mental effort (such as homework)

Group D

- Refuses to follow rules or adults' requests
- Loses temper
- Argues with parents or teachers
- Blames others for mistakes/misbehavior
- Swears
- Deliberately does things to annoy other people
- Is angry or resentful
- Carries a grudge; seems to have a "chip on shoulder"
- Touchy; easily annoyed by others
- Spiteful or vindictive

Group E

- Wets: daytime nighttime
- Soils: daytime nighttime

Group F

- Alcohol/drug use
- Smoking
- Caffeine Use

Group G

- Excessive appetite
- Underweight
- Exercises excessively
- Use of self-induced vomiting
- Misuse of laxatives
- Intense fear of gaining weight even though underweight
- Evaluates self based on body shape and weight

Group H

- Abnormal posture
- Clumsiness
- Muscle weakness

Group I

- Steals (circle **in** or **out** of home setting)
- Runs away overnight
- Lies
- Skips school
- Is cruel to animals
- Destroys property
- Gets into fights
- Has been physically cruel to other people
- Doesn't seem sorry for hurting others
- Sets fires/dangerous play with fire
- Has broken into someone else's house or car
- Legal problems

Group L

- Recurrent and upsetting thoughts of a past traumatic event_____
- Recurrent distressing dreams of a past upsetting event
- A sense of reliving a past upsetting event
- A sense of panic or fear to events that resemble an upsetting past event
- Spending effort avoiding thoughts or feelings associated with a past trauma
- Inability to recall an important aspect of a past upsetting event
- Persistent avoidance of activities or situations that cause him/her to remember a past upsetting event
- Marked decreased interest in important activities
- Feeling detached or distant from others
- Feeling numb or restricted in your feelings
- Feeling that his/her future is shortened
- Quick startle response
- Feeling like he/she is always watching for bad things to happen

Group M

- Impairment in the use of nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures and gestures to regulate social interactions
- Failure to develop peer relationships
- Lack of showing, bringing, or pointing out objects of interest to other people
- Lack of social or emotional reciprocity
- Inflexible adherence to specific, nonfunctional routines or rituals
- Hand or finger flapping or twisting
- Difficulty identifying when someone is teasing
- Fails to predict probable consequences in social events
- Difficulty making believe or pretending
- Talks about a single subject excessively
- Shows an intense, obsessive interest in certain intellectual subjects
- Unaware of or insensitive to the needs or feelings of others
- Demonstrates eccentric forms of behavior
- Preoccupation with specific subjects or parts of objects
- Expresses feelings of empathy inappropriately
- Seems unaware of social conventions or codes of conduct
- Becomes frustrated quickly when unsure of what is required
- Displays clumsy and uncoordinated gross motor movements

Group J

- Difficulty making and keeping friends
- Difficulty with teachers
- Poor choice of friends

Group K

- Inappropriate sexual talk
- Sexual abuse of others
- Overly friendly with strangers

FUNCTIONAL IMPAIRMENT

The reported symptoms have created difficulty in the following areas:

SCHOOL:

__not difficult __somewhat difficult __very difficult __extremely difficult

GETTING ALONG WITH OTHERS:

__not difficult __somewhat difficult __very difficult __extremely difficult

TAKING CARE OF THINGS AT HOME:

__not difficult __somewhat difficult __very difficult __extremely difficult

FAMILY IDENTIFICATION AND HISTORY

Please name each person (including parents, stepparents, adoptive parents, or full, half or step siblings) **CURRENTLY** living in the same household as this child/teen:

Person # 1	Age	Relationship to client
Person # 2	Age	Relationship to client
Person # 3	Age	Relationship to client
Person # 4	Age	Relationship to client
Person # 5	Age	Relationship to client

Is there another household in which the child lives? ____Yes ____No

Please name each person living in the second household as the child:

Person #1	Age	Relationship to client
Person #2	Age	Relationship to client
Person #3	Age	Relationship to client
Person #4	Age	Relationship to client
Person # 5	Age	Relationship to client

Has this child experienced the loss by death of any individual or pet significant in his/her life? If yes, please describe who, when and how: _____

Has this child experienced the divorce or breakup of the parents' relationship? If yes, please describe the child's reaction to the breakup. _____

Is this child adopted? _____ If so, at what age? _____
Describe any difficulties, if any, that are related to being adopted. _____

Describe any relationship difficulties this child/teen may have with any member of the household _____

Biological Mother's History: Age _____ Outside work _____
School: Highest grade completed _____ Marriages _____

Has mother, parents, or siblings experienced any of the following problems?

- Alcohol or drug abuse? Y N DK If yes, whom? _____
- Significant depression? Y N DK If yes, whom? _____
- Suicidal attempts? Y N DK If yes, whom? _____
- Significant anxiety? Y N DK If yes, whom? _____
- Mental illness? Y N DK If yes, whom? _____
- Hospitalization for emotional problems? Y N DK If yes, whom? _____
- Chronic physical illness? Y N DK If yes, whom? _____
- Anger problems? Y N DK If yes, whom? _____
- Learning disability/difficulty? Y N DK If yes, whom? _____
- Behavior problems? Y N DK If yes, whom? _____

Childhood atmosphere growing up (family position, abuse, illnesses, etc.) _____

Has mother ever experienced (circle if yes):

Sexual abuse Physical abuse Emotional abuse/Harassment

Has mother ever sought mental health treatment? Yes _____ No _____ If yes, for what purpose? _____

Biological Father's History: Age _____ Outside work _____
School: Highest grade completed _____ Marriages _____

Has father, parents, or siblings experienced any of the following problems?

- Alcohol or drug abuse? Y N DK If yes, whom? _____
- Significant depression? Y N DK If yes, whom? _____
- Suicidal attempts? Y N DK If yes, whom? _____
- Significant anxiety? Y N DK If yes, whom? _____
- Mental illness? Y N DK If yes, whom? _____
- Hospitalization for emotional problems? Y N DK If yes, whom? _____
- Chronic physical illness? Y N DK If yes, whom? _____
- Anger problems? Y N DK If yes, whom? _____
- Learning disability/difficulty? Y N DK If yes, whom? _____
- Behavior problems? Y N DK If yes, whom? _____

Childhood atmosphere growing up (family position, abuse, illnesses, etc.) _____

Has father ever experienced (circle if yes):

Sexual abuse Physical abuse Emotional abuse/Harassment

Has father ever sought mental health treatment? Yes _____ No _____ If yes, for what purpose? _____

(If Applicable)

Step or Adoptive Mother's History: Age_____ Outside work _____

School: Highest grade completed_____ Marriages_____

Has step or adoptive parent experienced any of the following problems?

Alcohol or drug abuse? Y N DK If yes, whom?_____

Significant depression? Y N DK If yes, whom?_____

Suicidal attempts? Y N DK If yes, whom?_____

Significant anxiety? Y N DK If yes, whom?_____

Mental illness? Y N DK If yes, whom?_____

Hospitalization for emotional problems? Y N DK If yes, whom?_____

Chronic physical illness? Y N DK If yes, whom?_____

Anger problems? Y N DK If yes, whom?_____

Learning disability/difficulty? Y N DK If yes, whom?_____

Behavior problems? Y N DK If yes, whom?_____

Childhood atmosphere growing up (family position, abuse, illnesses, etc.)_____

Has step or adoptive parent ever experienced (circle if yes):

Sexual abuse Physical abuse Emotional abuse/Harassment

Has step or adoptive parent ever sought mental health treatment? Yes_____ No_____ If yes, for what purpose?_____

(If Applicable)

Step or Adoptive Father's History: Age_____ Outside work _____

School: Highest grade completed_____ Marriages_____

Has step or adoptive parent experienced any of the following problems?

Alcohol or drug abuse? Y N DK If yes, whom?_____

Significant depression? Y N DK If yes, whom?_____

Suicidal attempts? Y N DK If yes, whom?_____

Significant anxiety? Y N DK If yes, whom?_____

Mental illness? Y N DK If yes, whom?_____

Hospitalization for emotional problems? Y N DK If yes, whom?_____

Chronic physical illness? Y N DK If yes, whom?_____

Anger problems? Y N DK If yes, whom?_____

Learning disability/difficulty? Y N DK If yes, whom?_____

Behavior problems? Y N DK If yes, whom?_____

Childhood atmosphere growing up (family position, abuse, illnesses, etc.)_____

Has step or adoptive parent ever experienced (circle if yes):

Sexual abuse Physical abuse Emotional abuse/Harassment

Has step or adoptive parent ever sought mental health treatment? Yes_____ No_____ If yes, for what purpose?_____

DEVELOPMENTAL HISTORY

Prenatal events:

Check: Planned pregnancy_____ Unplanned pregnancy____
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc.)_____

Birth and Postnatal period:

Birth weight_____ Length_____ Labor duration_____
Delivery: Vaginal_____ C-section_____ Full-term_____ Premature_____
Any other complications:_____

Mother’s health after delivery: Post delivery blues?_____ If yes, how long?_____

Primary caretaker for child: First year_____
Thereafter_____

Feeding history: breast_____ bottle_____ age weaned_____
Food allergies:_____
Eating problems:_____

Separations from mother and father: Why?_____
Age_____ How long?_____

Motor development:

(parentheses listed are approximate normal limits)

rolls over (3-5 months) ___yes ___no sit without support (5-7 months) ___yes ___no
crawls (5-8 months) ___yes ___no walks well (11-16 months) ___yes ___no
runs well (2 years) ___yes ___no rides tricycle (3 years) ___yes ___no
throws ball overhand (4 years) ___yes ___no
fine and gross motor coordination ___yes ___no

List any occupational therapy services:_____

Language development:

(parentheses listed are approximate normal limits)

several words besides dada, mama (1 year) ___yes ___no
names several objects – ball, cup (15 months) ___yes ___no
3 words together – subject, verb, object (24 months) ___yes ___no
vocabulary_____ articulation_____
comprehension_____

List any **current** problems:_____

List any speech or language services:_____

Early social development:

(parentheses listed are approximate normal limits)

smile (2 months) ____yes ____no shy with strangers (6-10 months) ____yes ____no

separates from mother easily (2-3 years) ____yes ____no

cooperative play with others (4 years) ____yes ____no

early peer interactions_____

special interests_____

relationships to family members_____

Toilet training:

age reached bowel control: day_____ night_____

age reached bladder control: day_____ night_____

current function_____

Early behavioral/discipline problems (prior to age 5 years):

- disobeys
- property destruction
- stealing
- rule breaking
- fire setting
- harming animals
- physical harm to others
- harm to self
- lying

Methods of discipline

Please describe:_____

How frequently used or needed?_____

Early emotional development (prior to age 5 years):

- Check:
- irritable
 - happy
 - cries excessively
 - easily calmed
 - content
 - defiant

nervous habits_____

fears/phobias_____

special objects (blankets, dolls, etc.)_____

ability to express feelings_____

Sexual development

Has this child sought any sexual information from parents? Yes_____ No_____

If yes, please describe nature of questions and manner they were handled:_____

Has this child ever behaved or spoken in a way that was not sexually appropriate for a person his/her age? Yes_____ No_____ Please describe:

Nature of comment or behavior:_____

Age of child at the time:_____

Who noticed or heard?_____

Any current concerns about your child's sexual behavior? Circle: Yes No

If yes, please describe:_____

Any concerns related to the use of Internet pornography or other forms of pornography?

Y N DK If yes, please describe_____

History of Abuse:

Physical abuse: by whom?_____ what ages?_____

Sexual abuse: by whom?_____ what ages?_____

Verbal/Emotional abuse: by whom?_____ what ages?_____

SUBSTANCE USE HISTORY:

Did you use chemical substances while pregnant with your child? ____ Yes ____ No
Does your child/teen consume alcohol? ____ Yes ____ No
Does your child/teen consume caffeinated beverages ____ Yes ____ No
Does your child/teen use tobacco? ____ Yes ____ No
Does your child/teen use street drugs? ____ Yes ____ No
Has your child/teen ever misused prescription medications (eg pain pills)? ____ Yes ____ No
Has alcohol or drugs caused any problem for your child/teen in the past or present?
____ Yes ____ No
Has your child/teen ever been in chemical dependency treatment? ____ Yes ____ No
Is there a history of any type of chemical use issues in the child’s family of origin
____ Yes ____ No

SOCIO-ECONOMIC HISTORY:

School History:

name of school _____ grade _____
number of schools attended _____ grades repeated _____
average grades _____ homework problems _____
specific learning disabilities _____
special services at school _____
strengths/activities _____
motivation _____
what have teachers said about the child/teen _____

Is your child employed? ____ Yes ____ No

Hobbies and leisure activities: _____

Extra-curricular activities/current interests _____

Social Support System:

____ supportive network
____ no friends
____ a few friends
____ substance use based friends

Legal:

Has your child/teen ever been charged with a legal violation? ____ Yes ____ No ____ Don’t Know
If yes please describe _____

Is your child/teen on probation? ____ Yes ____ No

Religion:

Religious preference _____
Spiritual beliefs are an important part of child’s life ____ Yes ____ No

EMOTIONAL/PSYCHIATRIC HISTORY

Please indicate all services that have been or currently are being used to address current problems.

___ Social Services/Social Worker ___ Counselor/Therapist

___ Family Therapist ___ Spiritual Advisor ___ Mentor

Prior *inpatient* treatment _____ Mo/Yr _____

Provider Name: _____

Prior *outpatient* treatment _____ Mo/Yr _____

Please describe your child’s experience with the above services. Was he/she helped? How did he/she feel about the above services and/or prior therapy?

MEDICAL HISTORY

Current medical problems: _____

Current medications: _____

Past medical problems/medications: _____

Name of physician _____

Any history of head trauma? _____

Ever any seizures or seizure like activity? _____

Any periods of spaciness or confusion? _____

Prior hospitalizations (place, cause, date, outcome): _____

Prior abnormal lab tests, X-rays, EEG, etc.: _____

Allergies/drug intolerances? (Describe): _____

Present Height _____ Present Weight _____

STRENGTHS

Overall strengths of child/teen – as viewed by parents _____

Overall strengths – as viewed by the child/teen _____

STRESSORS

Have any of the following caused stress for this child/teen? (Please check below. For any checked item, please write the year of occurrence behind the event, and include any specific details in the space below.)

- | | |
|---|--|
| <input type="checkbox"/> Moved | <input type="checkbox"/> Changed school |
| <input type="checkbox"/> School harassment, bullying, or violence | <input type="checkbox"/> Serious illness or injury in family |
| <input type="checkbox"/> Change in family financial status | <input type="checkbox"/> Family financial problems |
| <input type="checkbox"/> Job change in family | <input type="checkbox"/> Parent starting work outside home |
| <input type="checkbox"/> Divorce or separation | <input type="checkbox"/> Sibling leaving home |
| <input type="checkbox"/> Foster care placement | <input type="checkbox"/> Family legal problems |
| <input type="checkbox"/> Other out of home placement(s) | <input type="checkbox"/> Traumatic event(s) |
| <input type="checkbox"/> Parental conflict/family violence | <input type="checkbox"/> Housing inadequate |
| <input type="checkbox"/> Educational deficits | <input type="checkbox"/> Support group deficient |
| <input type="checkbox"/> Other Stressors (please list) _____ | |
| _____ | |
| _____ | |
| _____ | |