Granite City Counseling, LLC
Empathy. Encouragement. Empowerment.

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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 <u>currently</u> experiencing using the following scale:
0 – never; **1** – mild; **2** – moderate; **3** – severe

<u>Group A</u>

__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

<u>Group B</u>

__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 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

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

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.)

____Moved
____Changed school
____School harassment, bullying, or violence
____Serious illness or injury in family
____Change in family financial status
____Family financial problems
____Job change in family
____Parent starting work outside home
____Divorce or separation
____Sibling leaving home
____Foster care placement
____Family legal problems
____Other out of home placement(s)
____Traumatic event(s)
____Parental conflict/family violence
____Housing inadequate
____Educational deficits
____Support group deficient
____Other Stressors (please list) _____

_____

_____

_____