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Child/Adolescent Intake History Form: Part II

Child/Adolescent's name: _____
Date:_____

Presenting Problem (include precipitating factors:)

_____

_____

_____

_____

_____

List other adults involved in the daily care of this child:

Name	Relationship	Age	Any history of Emotional Problems

Circle any problems from the following list that pertain to your child:

Nervousness	Depression	Fears	Shyness
Sexual Problems	Suicidal Thoughts	Separation	Health Problems
Divorce	Finances	Temper	Nightmares
Family	Emotions	Gambling	Co-Workers
Alcohol/Drug Use	Friends	Children	Appetite
Anger	Self-control	Unhappiness	Being a Parent
Sleep	Stress	Work	Marriage
Relaxation	Headaches	Tiredness	Stomach Trouble
Legal Matters	Memory	Ambition	My Thoughts
Energy	Insomnia	Making Decisions	Loneliness
Inferiority Feelings	Concentration	Education	Career Choices

Other:_____

Page 2: Child and Adolescent Intake Form: Part II

Usual grade ranges: In the past:_____ Recently:_____

Please give the child's significant medical history: (Include medications/hospitalizations/injuries, etc.)

_____

_____

_____

Does the child have any current physical complaints? YES NO (If YES, please explain):

_____

_____

_____

List current medications with date started, dosage, frequency, and the physician who prescribed:

_____

_____

_____

Family Physician:_____

Date of last exam:_____

Address/City/Zip:_____

_____

Family – Social – Legal Issues:_____

_____

_____

Previous Treatment: YES NO With Whom:_____ When:_____

Interventions and Response to Prior Treatment:_____

_____