People In Need
Child Intake Information Form
(17 years old and under)

Date: _____ Child Name: _____ Client Case #_____

Age: ___ Sex: ____ Date of Birth: _____ Social Security Number: _____-_____-_____

Home Address: _____

Home Phone: _____ Referred by: _____

Is Child Adopted? ☐ No ☐ Yes, at what age? _____ Is Child in Foster Care? ☐ No ☐ Yes, how long? _____

Parents' Marital Status: ☐ Never Married ☐ Married Date: _____ ☐ Separated Date: _____

☐ Divorced Date:_____ ☐ Widowed Date: _____

Mother's Information:

Name: _____ Home Phone: _____

Address (if different from child): _____

Occupation: _____ Employer: _____ Business Phone: _____

Father's Information:

Name: _____ Home Phone: _____

Address (if different from child): _____

Occupation: _____ Employer: _____ Business Phone: _____

Please describe the reason for your visit:

_____

_____

Family and Household Composition: (List child's immediate family and significant relationships. In *Location* column, write **H** for people living with child and write city/state of residence for people not living with child. Under *Health Issues,* write any serious illness or injuries).

Name	Relationship	Age	Location	Health Issues

Parent/Guardian Information:

Who does the child currently live with: _____

Who is child's legal guardian: _____

Describe the physical and legal custody agreement: _____

_____

Location of noncustodial parent and extent of contact/visitation: _____

Additional Information: _____

_____

Educational History:

School: _____ City: _____ Phone: _____

Grade: _____ Teacher(s): _____

Placement: ☐ Mainstream ☐ Gifted/Honors ☐ Retention, what grade? _____

☐ Special Education (IEP), type: _____ ☐ Other Services _____

Describe strength and problem areas (friendships, behavioral concerns, academic concerns, interactions with teachers):

_____

_____

_____

Please list any significant stressors that your child/family have experienced (accidents, deaths, moves, school or job change, illness/injury, violence, crime victimization, etc.): _____

_____

_____

_____

Please describe any pending legal matters (include visitation/custody proceedings, truancy):

_____

_____

_____

History of Sexual, Physical or Psychological Abuse:

☐ Sexual abuse ☐ Raped ☐ Victim/witness of domestic violence

☐ Physical abuse ☐ Psychological abuse ☐ Sexual activity with a family member or relative

Has the child ever experienced any kind of sexual, physical, or psychological abuse (nature of abuse, duration, age, people involved, and charges filed/reporting of incident)?

_____

_____

_____

_____

Please list any previous MENTAL HEALTH SERVICES (outpatient/inpatient) your child has received:

Provider/Agency	Dates	Reason

Client Signature *(if applicable)*: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Health Information

Primary Care Physician: _____ Height: _____ Weight: _____

Has the child had any seizures or convulsions: ☐ No ☐ Yes, please explain when and what caused them:

_____

Allergies: ☐ No ☐ Yes, please list: _____

Current health problems or concerns:

PROBLEM/CONCERN	HOW LONG	NAME OF TREATING DOCTOR

Medical Hospitalizations (especially involving head/neck/spine):

FOR SURGERIES	OUTCOME/STATUS	DATE(S)

FOR MAJOR ILLNESS/INJURY	TREATMENT/OUTCOME	DATE(S)

Current Medications/Medications taken within the year (prescribed and non-prescribed):

MEDICATION	DOSE/FREQUENCY	REASON	SIDE EFFECTS

Family Psychiatric/Medical History (major illness or disease that runs in the family):

FAMILY MEMBER(S)	ILLNESS/DISEASE	TREATMENT	STATUS/OUTCOME

Immunization History:

IMMUNIZATION	DATE(S)	PROBLEMS/SIDE EFFECTS

Girls Only:

Age you began to menstruate: ____ Explain any problems with menstruation: _____

_____

	YES/NO	IF YES, HOW MANY	DATE(S)
Pregnancies			
Miscarriages			
Abortions			

Lifestyle/Health Habits:

List any past or present bowel/urinary problems (diarrhea, constipation, incontinence, bed wetting):_____

_____

Hours of sleep per night: _____ Describe any sleep problems: _____

_____

Exercise/physical activities (how often, how long, what type):_____

_____

Describe any problems with appetite: _____

Any significant changes in weight (20+ lbs. in 6 months): ☐ No ☐ Yes if yes, please describe and give any reasons for change: _____

Substance Use History (please check all past/present use):

Average daily consumption of coffee, tea, cola, or other caffeine: _____

☐ No tobacco use ☐ Former tobacco user who has quit, when: _____

☐ Tobacco user (cigarettes, cigars, chew, snuff, e-cig) Average daily tobacco use:_____

Depressants:

☐ Alcohol ☐ Barbiturates ☐ GHB ☐ Tranquilizers (Ativan, Valium, Diazepam, Librium, Xanax)

Age at first use: _____ Date of last use: _____ Frequency/length of use: _____

Method: _____ Quantity: _____

Stimulants:

☐ Methamphetamine ☐ Amphetamine (speed) ☐ Cocaine ☐ Crack

Age at first use: _____ Date of last use: _____ Frequency/length of Use: _____

Method: _____ Quantity: _____

Hallucinogens:

☐ LSD ☐ MDMA (ecstasy)

Age at first use: _____ Date of last use: _____ Frequency/length of Use: _____

Method: _____ Quantity: _____

Opiates:

☐ Heroin ☐ Methadone ☐ Morphine ☐ Suboxone ☐ Other Opiates (OxyContin, Percocet, Vicodin, etc)

Age at first use: _____ Date of last use: _____ Frequency/length of Use: _____

Method: _____ Quantity: _____

Other:

☐ Marijuana ☐ PCP ☐ Inhalants ☐ Steroids ☐ Over the Counter (cough syrup, caffeine, etc)

Age at first use: _____ Date of last use: _____ Frequency/length of Use: _____

Method: _____ Quantity: _____

Client Signature *(if applicable)*: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____