Social Butterfly Counseling

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Child/Adolescent Intake Form
(TO BE COMPLETED BY PARENT)

General Information

Child's Name: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Email: _____

Referral Source: _____

Primary Care Physician: _____

Family Information

Please list all significant parental figures involved in child's care.

Name	Age	Gender	Relationship to Child	Highest Education	Occupation

Marital status of biological parents (circle): single / married / divorced / remarried / living together

Date of marriage: _____ Date of divorce: _____

Custody arrangements: _____

Previous marriages and length for mother: _____

Previous marriages and length for father: _____

Please list all of child's siblings.

Name	Age	Gender	Relationship	Currently living in home?	Behavioral/emotional problems?
				YES NO	
				YES NO	
				YES NO	
				YES NO	

Family Mental Health History

Please indicate if there is a family history of mental health problems. If so, indicate the family member.

	Yes (If yes, who?)	No
Alcohol/Substance Use		
Anxiety		
Depression		
Domestic Violence		
Eating Disorders		
Schizophrenia		
Suicide Attempts		

Child's Developmental History

Difficulties during pregnancy or delivery:

_____

_____

_____

_____

_____

Concerns related to child's development:

_____

_____

_____

_____

_____

Child's Health History

Major illnesses, injuries, surgeries, accidents, medical conditions:

Date	Incident	Treating Physician

Comments: _____

_____

Mental health services:

Date	Reason	Therapist/Psychiatrist

Comments: _____

_____

Psychiatric hospitalizations:

Date	Reason	Hospital

Comments: _____

_____

Current Medications:

Medication	Dosage	Reason	Frequency	Prescribing Physician

Comments: _____

_____

Child's Behavioral Health History

To your knowledge, has your child ever had any of the following?

Diagnosis/Problem	Yes	No	Reported by (teacher, doctor, etc.) ***do not include names**
Aggression			
Alternating mania and depression			
ADD/ADHD			
Autism			
Behavior/discipline problem at home			
Behavior/discipline problem at school			
Conduct Disorder			
Depression			
Emotional disturbance			
Hospitalized for emotional problems			
Trouble with law			
Learning disability or dyslexia			
Learning problems at school			
Muscle twitches or motor tics			
Obsessive thoughts or compulsive actions			
Alcohol use or abuse			
Drug use or abuse			
Thoughts of suicide			
Other psychological/ behavioral problems (describe)			

Education

School			
Current Grade/Year		Typical Grades	

Has your child ever been held back in school?

Describe: _____

_____

Has your child ever been suspended or expelled?

Describe: _____

_____

Has your child ever been tested for intellectual ability, or other psychological testing?

Describe: _____

_____

Does your child have a 504 Plan or IEP?

Describe: _____

_____

Does your child receive special education services?

Describe: _____

_____

Does your child's teacher have concerns about your child?

Describe: _____

_____

Is your child currently participating in any school/classroom interventions?

Describe: _____

_____

Please describe any other concerns you have for your child related to school:

_____

_____

_____

_____

Technology

To your knowledge, how many hours per day does your child spend…

	<1 /day	1-2 /day	2-3 /day	3-4 /day	4+ /day
Using a computer (for fun or for classwork)					
Using a smart phone or tablet					
Watching TV or movies (including Netflix, Youtube, etc.)					
Playing video games or games on phone/tablet					
Using social media (Facebook, Instagram, Snapchat, Twitter, Tumblr, etc.)					

Have you ever had difficulty getting your child to stop using their phone or computer?

Describe: _____

_____

_____

_____

Do you have any concerns about your child's use of technology or social media?

Describe: _____

_____

_____

_____

_____

Current Reasons for Seeking Treatment

Please describe the reasons you are seeking treatment at this time.

_____

_____

_____

_____

Please briefly describe the history of these concerns, listing all factors that may contribute.

_____

_____

_____

_____

Please list the things you have tried or done to help your child.

_____

_____

_____

_____

Please describe your child's strengths.

_____

_____

_____

_____