C2 Your Health, PC

Intake Form for Children and Adolescents

Child / Adolescent Name: ____________________________________ Today's date: ______________

DOB: ____________________ Age: _____________ Gender: ___________________

Grade: ____________ | School: ____

Parent / Guardian's Name:	Parent / Guardian's Name:
____________________________________	____________________________________
Relationship: _________________________	Relationship: _________________________
Address: ____________________________	Address: ____________________________
_____________________________________	_____________________________________
Phone (Home): ________________________	Phone (home): ________________________
Phone (Cell): __________________________	Phone (Cell): __________________________
Phone (Work): _________________________	Phone (Work): _________________________
Email: ________________________________	Email: ________________________________
Marital Status: _________________________	Marital Status: _________________________
Name of Spouse: ________________________	Name of Spouse: ________________________

(Please circle the address where the child / adolescent primarily resides. If equal time spent at each address, please circle both)

If the primary address of the child / adolescent is different from above, please list that address:

____

City: ___________________________________ State: _____________ Zip: _____________________

Brief explanation of why child / adolescent resides here: _______________________________________

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This child / adolescent is in the legal custody of: ____

____

(Please specify ALL parties who have legal custody and whether it is sole or shared / joint)

Who referred you to our clinic? ____

Why did you seek out our services?____

Has the client ever been in mental health treatment before? YES NO

Has the client ever had a psychological / neurological / academic evaluation? YES NO

Does the client have a history of criminal behavior? YES NO

Has the client ever expressed suicidal thoughts? YES NO

Has the client ever expressed wanting to hurt someone else? YES NO

Has the client ever been significantly maltreated or traumatized? YES NO
(eg, sexually / physically abused, neglected, witness to violence / death, been in serious accident)

Has the client ever significantly maltreated others? YES NO
(eg engaged in sexual / physical abuse, caused harm to people or animals)

Does the client currently use alcohol or drugs (including tobacco)? YES NO
Is yes, please specify:

____

Is the client concerned about his/her weight / physical health? YES NO

List all current prescribed medications the child / adolescent is taking:

Name: ____________________________ Purpose: _______________________________

Name: ____________________________ Purpose: _______________________________

Name: ____________________________ Purpose: _______________________________

Name: ____________________________ Purpose: _______________________________

List any major medical / physical conditions: ____

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Briefly describe any concerns you have regarding school, peer relationships, and/or the family:

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