Brandywine Valley Counseling
And Neurofeedback Center

CHILD/ADOLESCENT INTAKE FORM

Name: _____ Date:_____
Date of Birth: _____

Mother's Name: _____

◯ Natural Parent ◯ Step Parent ◯ Adoptive Parent ◯ Relative

Father's Name: _____

◯ Natural Parent ◯ Step Parent ◯ Adoptive Parent ◯ Relative

Additional Parent(s):_____
Address:

Home Phone: _____ Cell Phone: _____
E-mail address: _____

Referred by: _____

Insurance company: _____
Insurance ID number: _____
Insurance group number: _____
Insurance phone number (behavioral health): _____

Has child/adolescent previously received any type of mental health services (psychotherapy, psychiatric services, hospitalizations, etc.)? If yes, please give names and approximate dates of treatment.

Medications and dosages:

Allergies to foods or medications:

Emergency Contact: _____
Phone number: _____ Relationship to child: _____

LIVING ARRANGEMENTS

1. Number of moves in child/adolescent's life: _____
Was child/adolescent ever placed, boarded or lived away from primary family?

2. List household members and their relationship to child/adolescent:

GENERAL PHYSICAL AND MENTAL HEALTH INFORMATION

1. How would you rate child/adolescent's current physical health?

◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very Good

List any specific health problems child/adolescent is experiencing:

Please list any physical injuries or head impacts (even without loss of consciousness), including car accidents, slips and falls, surgeries, etc.:

2. How would you rate child/adolescent's current sleeping habits?

◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very Good

Please describe child/adolescent's bedtime routine:

3. How many times per week does child/adolescent generally exercise? _____

What types of exercise?

4. List any difficulties child/adolescent has with appetite or eating patterns:

Does child/adolescent get enough proteins and nutrients in their diet?

5. Is child/adolescent currently experiencing sadness, grief, or depression? If so, for how long?

6. Is child/adolescent currently experiencing anxiety, panic attacks or phobias? If so, for how long?

7. Is child/adolescent experiencing any chronic or intermittent pain? If yes, please describe.

8. Please describe any alcohol use (how much, how often):

9. Please describe any recreational drug use (how much, how often):

10. (If applicable) Is your adolescent currently in a romantic relationship? If so, for how long?

Please rate relationship satisfaction on a scale of 1-10 _____

11. What are child/adolescent's presenting problems

☐ Temper outbursts	☐ Impulsive	☐ Shy/Withdrawn
☐ Stubborn	☐ Daydreaming	☐ Disobedient
☐ Fearful/Anxious	☐ Depressed	☐ Infantile
☐ Stealing	☐ Lying	☐ Clumsy
☐ Mean to others	☐ School trouble	☐ Overactive
☐ Destructive	☐ Bowel/bladder control	☐ Inattention
☐ Bed wetting	☐ Sleeping problems	☐ Eating problems
☐ Self-harming	☐ Distractible	☐ Peer conflict
☐ Head banging	☐ Drug/alcohol use	☐ Phobic
☐ Rocking	☐ Social deficits	☐ Anger
☐ Dawdles	☐ Oppositional	☐ Argumentative
☐ Whines	☐ Cries easily	☐ Yells/Screams
☐ Teases/Provokes	☐ Interrupts	☐ Impatient

Other problems:

FAMILY MENTAL HEALTH HISTORY

Please indicate if there is a family history of the following, as well as the family member's relationship to child/adolescent (ex. father, grandmother, aunt, etc.)

Condition	Yes or No	Family member(s)
Depression	_____	_____
Anxiety	_____	_____
Alcohol/Substance Abuse	_____	_____
Domestic Violence	_____	_____
Other abuse	_____	_____
Eating Disorders	_____	_____
Obsessive Compulsive Behavior	_____	_____
Schizophrenia	_____	_____
Suicide attempts	_____	_____

BEHAVIORAL/FAMILY HISTORY

1. Does child/adolescent experience behavioral or academic problems at home or school? If so, please explain.

2. Did child/adolescent meet developmental milestones at an appropriate age? If not, please explain.

3. Did mother have any complications before or during pregnancy? If so, please explain.

4. Are there any special circumstances in the home (ex. divorce, illness, intense arguing, deaths, etc.)? If so, please briefly explain.

5. Has child/adolescent experienced physical, emotional and/or sexual abuse? If so please briefly explain.

EDUCATIONAL HISTORY

Name of School/Daycare: _____

Types of classes: _____

1. Does child/adolescent receive special services at school? If so, please explain.

2. Does child/adolescent attend extracurricular activities?

3. In school, how many friends does child/adolescent have?

ADDITIONAL INFORMATION

1. Do you consider your family to be spiritual or religious? If so, please explain.

2. What do you or your child/adolescent consider to be some of their strengths?

3. What do you or your child/adolescent consider to be some of their weaknesses?

4. What would you and/or your child/adolescent like for them to accomplish during their time with us?