Discover·Explore·Empower

## Client Intake Form-Child/Adolescent

*Welcome to Thrive Counseling!*

Please provide information to assist your initial sessions with your therapist.

Name of child:_____ Date:_____

DOB: _____

Parent name:_____

Other Parent/Significant Caregiver: _____

**Reason for seeking therapy:**

**Symptoms**:_____

_____

_____

_____

**Current Medications and dosage:** _____

_____

_____

_____

2085 County Road D East Maplewood MN 55109 · Tel: 651-207-6977 · Fax: 651-340-6783

**Current Providers:** (Therapist, Psychiatrist, County Worker, Adoption worker, Medical doctor, etc):

_____

_____

_____

_____

**Referral source:**

□ Internet/Social Media: _____ □Provider_____

□Other:_____

## Mental Health History of Child/Teen

Hospitalizations (for Mental Health ONLY):

Hospital: Dates:

_____ _____

_____ _____

Day Treatment:

_____ _____

Previous Providers (Therapists, Psychiatrists, County workers, Adoption workers):

_____ _____

_____ _____

_____ _____

Previous/current assessments (Psychological/neuropsych assessments, IEPs, etc.):

Please attach copy for your provider.

_____ _____

_____ _____

## Living Situation

Primary Household:

| Name | Relationship | Age | Occupation/School | Highest level education | Quality of relationship |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Previous Foster Care:_____

## Developmental History

| **Prenatal care and Pregnancy: Parent:** | **Yes** | **No** | **Unknown** |
|---|---|---|---|
| had to take medications: Specify: | | | |
| Took illicit drugs: Specify: | | | |
| Drank Alcohol | | | |
| Experienced abuse | | | |
| Other: | | | |
| Birth Complications: Specify: | | | |

Met Developmental Milestones on time? (If not which one were delayed)

_____

| **Childhood/Adolescent Health Concerns:** | **Yes** | **No** | **Unknown** |
|---|---|---|---|
| Accidents (car, bike, head injury, broken bones): | | | |
| Hospitalizations (medical only): | | | |
| Major Illness: | | | |

**Educational Information:**

Does your child receive special education services? □Yes □No

Individualized Education Plan? (Please provide copy) □Yes □No

504 Plan? (Please provide copy) □Yes □No

Name of School: _____ Grade:_____

Previous schools:_____

## Trauma History

Has your teen/child experienced the following:

□Physical Abuse □Verbal Abuse □Sexual Abuse □Neglect

□Subjected to Domestic Violence/Abuse □Witnessed Domestic Violence

□Separated from birth parent (How many times_____ ages_____)

□Experienced Termination of Parental Rights (age/date):_____

□Adoption (age/date):_____

□Disrupted Adoption: (age/date): _____

□Other Significant Loss: (describe):_____

Children's Protective Services (CPS) involvement with family? □ Yes □No

If yes, please describe the situation bringing in CPS:_____

Name of caseworker assigned to family:_____

Name of Guardian ad Litem (GAL) appointed:_____

Family *Mental* Health (diagnoses, symptoms, chemical use):

Mother/Mother's side:_____

Father/Father's side:_____

Family *Medical* Health (Heart disease, diabetes, etc.):

Mother/Mother's side:_____

Father/Father's side:_____

## Tobacco, Drug and Alcohol Use-Child/Adolescent

CAGE:

1. Have you ever felt you ought to cut down on your drinking or drug use? □Yes □No
2. Have people annoyed you by criticizing your drinking or drug use? □Yes □No
3. Have you felt bad or guilty about your drinking or drug use? □Yes □No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? □Yes □No

Do you want additional information or help with chemical use? □Yes □No

Support System:

_____
_____
_____
_____

Strengths/Hobbies:

_____
_____
_____
_____

Challenges/Things to work on:

_____
_____
_____

What is your end goal of your therapy/what would you like things to look like for your child and your family:

_____
_____
_____
_____

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