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NEW CLIENT INFORMATION

Child, Adolescent, & Family Therapy
Intake Form

To be completed by each adult in the family and any other adult who parents the children in this family. Children 13 years and older should also complete this form to the best of their ability. Please sign and date where indicated.

Name _____ DOB ___/___/____ Age _____

Race/Ethnicity _____ Gender _____

Preferred Phone _____ □Cell □Home □Work Other: _____

Email _____

Preferred Communication: □Cell □Home □Work □Email

Okay to leave a message on my: □ Home □Cell □ Work □ Other

Residential Address _____
City _____ Zip _____

May I send mail to this address? Yes No

May I use your email to confirm appointments? Yes No

Employer _____
Type of Work _____

Relationship Status Single /Married /Partnership /Divorced /Separated /Widowed /Other

Emergency Contact_____ Phone_____

Relationship_____

I. PROBLEM HISTORY & PRESENTING CONCERN

A. What prompted your family to seek therapy at this time?

_____
_____
_____
_____

B. How is each family member impacted by the problem?

_____
_____
_____
_____
_____
_____

C. How does each family member contribute to the problem?

_____
_____
_____
_____
_____
_____

D. If the problem were resolved, how would you know? What would be different?

_____
_____
_____
_____

E. Please describe your family's strengths. _____
_____
_____
_____

F. Please describe your family's challenges or struggles. _____
_____
_____
_____

G. (To parents/guardians): Please describe your parenting style. _____
_____
_____
_____

H. Please describe your goals for therapy. _____
_____
_____

I. Have you ever been in therapy before? ___ Yes ___ No

With whom? _____

How would you describe your past experience in therapy? _____

_____

_____

_____

II. PERSONAL HISTORY

A. Describe current living situation (household members, living situation, length of time in home):

_____

_____

_____

_____

_____

_____

Do you ever feel unsafe at home? If you do not feel safe, please explain: _____

_____

_____

_____

Do you have any concerns about the way anger is handled in your relationship/family/living situation now? If yes, please explain. _____

_____

_____

B. *(To parents/guardians)*: Children

Name	Age	Gender	Location
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. Education

_____

_____

_____

D*. (To parent/guardian)*: Employment

What kind of work have you done in the past?

_____

_____

What kind of work are you doing now?

_____

_____

Are you satisfied with your current work situation? _____ Yes _____ No
If no, briefly describe why:

_____

_____

_____

Are there other sources of income (government benefits, retirement, trust fund, etc)?

_____

_____

III. PHYSICAL & MENTAL HEALTH HISTORY

How would you describe the current state of your health? _____

_____

_____

_____

Do you have or have you ever had:

- o Epilepsy
- o Abdominal/digestive problems
- o Diabetes
- o Heart Problems
- o Severe headaches
- o High blood pressure
- o Surgery
- o Breathing problems
- o Under-eating
- o Over-eating
- o Vomiting
- o Other eating problems
- o Sexual problems
- o Tobacco Use
- o Drug use
- o Alcohol use
- o Depression
- o Lack of motivation
- o Mental Illness
- o Mood Swings
- o Compulsions
- o Sleep disturbances
- o Temper outbursts
- o Over work
- o Chronic unemployment
- o Phobic reactions
- o Submissive behavior
- o Impulsivity
- o Obsessive thoughts
- o Concentration problems
- o Aggressive behavior
- o Crying
- o Nervous tics
- o Flashbacks
- o Withdrawal/isolation
- o Anxiety
- o Panic attacks
- o Hypervigilance
- o Over spending
- o Loss of control
- o Other, please explain:

  _____

  _____

Current Medications:

_____
_____
_____
_____

Have you ever had suicidal/homicidal thoughts? ____ Yes ____ No

If yes, please explain: _____
_____

Have you ever had a suicide/homicide plan? ____ Yes ____ No

If yes, please explain: _____
_____
_____

Have you ever attempted suicide? ____ Yes ____ No

If yes, please give date(s) and circumstances: _____
_____
_____

Have you ever attempted to harm someone else? ____ Yes ____ No

If yes, please explain: _____
_____
_____

Are you thinking about suicide now? ____ Yes ____ No

If yes, please explain: _____
_____
_____

Are you thinking about hurting someone else now? ____ Yes ____ No

If yes, please explain: _____
_____
_____

<u>IV. Alcohol and Substance Use</u>

Have you ever been treated for alcohol or drug dependence/abuse?
____Yes ____ No

Have you ever felt like you should cut down on alcohol or other drug use?
____Yes ____ No

Has a friend or relative ever discussed concerns about your drug use?
____Yes ____ No

Is there a history of problem with alcohol or drug use in your family?
____Yes ____ No

Have you received help for drug or alcohol dependency? ____ Yes ____ No

When? _____ Where? _____

Check one: **Treatment was ____ helpful ____ not helpful. Please explain.**

_____
_____
_____
_____
_____

V. FAMILY HISTORY

Has any member of your family had any of the following? (please specify who)

- Drinking problem: _____
- Drug problem: _____
- Depression: _____
- Depression with highs and lows: _____
- Mental illness: _____
- Incarceration: _____
- Angry/abusive: _____
- Abused as a child: _____
- Suicidal/Suicide attempt: _____

Childhood

What role did (or do) you have in your family?

_____
_____
_____

Please describe your developmental history. Did you struggle with meeting developmental timelines and/or a learning difficulty?

_____
_____
_____
_____
_____

Did (or do) you struggle with behavior problems as a child or a teenager?

_____
_____
_____
_____

Do you remember seeing anything happen in your family that scared you? If so, explain.

_____
_____
_____

How did (or do) your parents/caregivers get along? _____
_____
_____

Were you or any of your family members abused in any way or mistreated? _____
_____
_____
_____
_____
_____

VI. RELATIONSHIP HISTORY

Describe current relationship: _____
_____
_____
_____
_____

Have you ever been or are you currently concerned about harming your partner? If yes, please explain:

_____
_____
_____
_____

Have you ever felt afraid of your partner? If yes, please explain:

_____
_____
_____
_____

VII. LEGAL ISSUES

EPOs, Criminal Charges, Incarceration, Custody and Divorce issues, CPS/APS – past and present

Please describe any legal issues with which you are involved currently or in the past.

_____
_____
_____
_____
_____
_____

VIII. SOCIAL SUPPORT

Describe your peer/social groups/friendships: _____

_____
_____
_____
_____
_____

Have your parents, relatives or friends interfered with your job, school or relationship activities? If yes, briefly explain: _____

_____
_____
_____

How comfortable do you feel in social settings?

____ Very relaxed ____ Relatively relaxed ____ Relatively uncomfortable
____ Very uncomfortable
Explain: _____

_____
_____
_____

What kinds of activities do you engage in for fun? _____

_____
_____
_____

IX. ABUSE HISTORY

Has anyone hurt you, or done anything to you that made you feel bad about yourself?

_____
_____
_____
_____
_____

X. SPIRITUAL ASSESSMENT

***(To Parents/Guardian)*: What was your religion/faith experience as a child?**

_____
_____
_____

What is your religion/faith experience now?

_____
_____
_____

How has your life experience led you to make sense of your world?

_____
_____
_____
_____

XI. SELF-ASSESSMENT

Please list five qualities/strengths that you see in yourself: _____

_____
_____
_____

Is there anything else you think would be helpful for me to know about you or your situation?

_____
_____
_____
_____

By signing below, I confirm the information I provided on this document to be complete and truthful to the best of my knowledge.

Client Name (please print) _____

Signature of Client _____
(or authorized representative)

Date _____