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Manassas, VA 20110

**Child / Adolescent Client Intake Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Date of first appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (1) Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian (2) Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe Guardianship/Custody Agreement (A legal guardian must be present at the intake assessment)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please take your time in providing the following information. The questions are designed to help me begin to understand your child so that our time together can be as productive as possible.

**All information provided is confidential**.

**Referred by:**

\_\_Medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_My Website: https://empowerment-therapy-center.com/ PsychologyToday

\_\_Friend/Family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has the patient previously received any type of mental health services?** \_\_Yes \_\_No

If yes, which of the following?:

\_\_Psychotherapy \_\_Medication \_\_Outpatient \_\_Hospitalizations \_\_Inpatient Hospitalization

**If yes, please provide:**

Name of provider or facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Briefly, what brings your child in today?**

**When did the problem first start?** Within the last: \_\_30 days \_\_6--12 months \_\_2 years \_\_During adolescence \_\_During childhood

**What areas of your child’s life have been affected because of this problem?**

**Is your child currently experiencing overwhelming sadness, grief or depression?** \_\_Yes \_\_No

If yes, for approximately how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Any Suicidal Thoughts?**\_\_ Current? \_\_Past? – How long ago?\_\_\_\_\_\_\_\_ Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your child currently experiencing anxiety, panic attacks or have any phobias?** \_\_Yes \_\_No

If yes, when did your child begin experiencing this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Any History of self-harm?** \_\_Current? \_\_Past? – How long ago?\_\_\_\_\_\_\_ Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\*Any thoughts about harming others?** \_\_Current? \_\_Past? – How long ago? \_\_\_\_\_\_\_\_ Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please describe any major losses or traumas your child has experienced:**

**What significant life changes or stressful events has your child experienced recently?**

**What would you like to see accomplished during your child’s time in therapy?**

**Family History**

Where was the patient born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where did the patient grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_City \_\_Suburbs \_\_Country

Please list the patient’s **parents, step-parents,** **siblings, and any other significant family members**.

Please use additional space on the back if needed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Where do they live now?** | **If deceased, age and cause of death** |
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Who has the patient lived with throughout their childhood?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother's occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father's occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the section below identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc).**

|  |  |  |
| --- | --- | --- |
| **Condition** | **Please Circle** | **List Family Member** |
| Alcohol/ Substance Abuse | Yes / No |  |
| Anxiety | Yes / No |  |
| Depression | Yes / No |  |
| Domestic Violence | Yes / No |  |
| Sexual Abuse | Yes / No |  |
| Eating Disorders | Yes / No |  |
| Obesity | Yes / No |  |
| Obsessive Compulsive Disorder | Yes / No |  |
| Schizophrenia | Yes / No |  |
| Suicide Attempts | Yes / No |  |
| Other diagnosed mental health condition? | Yes / No: Which was?: |  |

**Guardians’ Marital Status:**

Primary Guardian #1 (PG#1) / Primary Guardian#2 (PG#2)

PG#1 / PG#2

\_\_ \_\_ Never Married

\_\_ \_\_ Domestic Partner

\_\_ \_\_ Married

\*\*If married, how long have you been married, and what is your partner’s name:

(PG#1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (PG#2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Separated

\_\_ \_\_ Divorced -- For how long? \_\_\_\_\_\_\_\_\_

\_\_ \_\_ Widowed: Please provide your partners name and year deceased: (PG#1 or PG#2?-Circle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Parent(s) currently in a romantic relationship?

\_\_ \_\_ Yes -- How long? (PG#1)\_\_\_\_\_\_\_ (PG#2)\_\_\_\_\_\_\_

\_\_ \_\_ No

What is the patient’s Gender?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred pronoun(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the patient’s Sexual Orientation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any issues related to gender or sexual orientation that might be relevant to treatment?

**Physical Health**

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If your child has a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your child’s health.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication/Supplement** | **Dosage** | **Condition** | **Date Began/Stopped** |
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**Prescribing provider(s) and contact information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone, email, or Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you rate the patient’s current physical health?**

\_\_Poor \_\_Unsatisfactory \_\_Satisfactory \_\_Good \_\_Very Good

**Please list any specific and significant health problems the patient is currently experiencing:**

**How would the patient rate their current sleeping habits?**

\_\_Poor \_\_Unsatisfactory \_\_Satisfactory \_\_Good \_\_Very Good

**If the patient is having problems, in which phase of sleep are they experiencing issues?**

\_\_Falling asleep \_\_Staying asleep \_\_Awakening early \_\_Sleep apnea

**Please list any other specific sleep problems the patient is currently experiencing:**

How many times per week does the patient generally exercise? \_\_\_\_\_\_\_\_\_\_\_\_ What types of exercise does the patient participate in?:

Is the patient currently experiencing any chronic pain? \_\_No \_\_Yes If yes, please describe:

**Substance Use/ Abuse**

**Please describe current use of alcohol, cigarettes, and/or recreational drugs:**

**Please describe previous use of alcohol, cigarettes, and/or recreational drugs:**

**Additional Information**

**Describe the patient’s strengths and limitations related to education:**

**Is there an IEP/504 Plan?** \_\_Yes \_\_No

**Describe the patient’s social relationships:**

**What does the patient enjoy doing in their free time? What do they do to relax?**

**Is the patient spiritual or religious? If yes, please describe their faith or belief:**

**What are some of the patient’s strengths?**

**What are some of the patient’s weaknesses?**

**Any additional Information that might help your child’s clinician better understand your child’s unique circumstances:**

**Reviewed by (Therapist/Supervisor):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 Print Signed Date

\*See biopsychosocial assessment for additional notes\*