Life Point Counseling, LLC
.....finding hope at every point in life

CHILD & ADOLESCENT INTAKE INFORMATION

All information provided in this application is considered part of the patient file and is, therefore, confidential. The information you provide is helpful in determining what services are most beneficial to you. Please fill out all parts.

CLIENT'S FULL NAME	AGE	DATE OF BIRTH	☐MALE ☐FEMALE ☐OTHER_____

FORM COMPLETED BY (IF SOMEONE OTHER THAN THE CLIENT)	RELATIONSHIP TO CLIENT

PURPOSE FOR TREATMENT

Why is the client seeking services at this time? (Describe concerns, worries, etc.)

How long have these problems been present?

On a scale of 1 (low) to 10 (high), how would you rate the impact of these problems in the child/adolescent's life? 1 2 3 4 5 6 7 8 9 10

LIVING ARRANGEMENT

Please describe who client is living with: (Name, relationship, etc.)

☐ with Family ☐ Shelter ☐ Group Home ☐ Foster Home ☐ Institute ☐ Half-way home ☐ Alone ☐ Correctional

☐ Non-Relative ☐ with Relative ☐ Other:_____

FAMILY HISTORY

What is client's current family/parent's situation?

☐ Single ☐ In Relationship ☐ Married ☐ Engaged ☐ Widowed ☐ Separated ☐ Remarried ☐ Divorced ☐ Other_____

Custody/Placement Agreement (Please bring a copy of court paperwork, if applicable):

Is there any information about the parents' relationship that would be beneficial to counseling? If so, please explain:

FAMILY

	Name:	Additional Information:	Date of Birth:	Age:
Mother:				
Father:				
Step-Mother:				
Step-Father:				
Siblings:		☐ Half ☐ Full ☐ Step		
		☐ Half ☐ Full ☐ Step		
		☐ Half ☐ Full ☐ Step		
		☐ Half ☐ Full ☐ Step		
		☐ Half ☐ Full ☐ Step		
		☐ Half ☐ Full ☐ Step		

CHILDHOOD HISTORY

Where was client born?

Where did client grow up?

EDUCATIONAL HISTORY

Highest grade completed: *Primary:* K 1 2 3 4 5 6 7 8 *High School:* 9 10 11 12

Presently attending school? ☐Yes ☐No If yes, where?

Retained in any grades? ☐Yes ☐No If yes, what grades?

Skipped any grades? ☐Yes ☐No If yes, what grades?

Has client ever been expelled or suspended? ☐Yes ☐No If yes, why?

Has client participated in special education? Please specify: ☐*N/A* ☐*Emotional Disorders* ☐*Learning Disability* ☐ *Cognitive Deficits*

Has client had any of the following difficulties at school?

☐ Incomplete homework	☐ Learning problems	☐ Poor grades	☐ Speech problems
☐ Referrals and/or detentions	☐ Teased or picked on	☐ Gang influence	☐ Attendance problems
☐ Individual Education Plan	☐ 504 Plan (I.e. ADHD, Autism)	☐ Others: _____	

CURRENT PRESENTING PROBLEMS & SYMPTOMS

☐ Arguing	☐ Distracted	☐ Impulsiveness	☐ Short attention span
☐ Alcohol Abuse	☐ Eating Problems	☐ Inattentive	☐ Shyness
☐ Angry	☐ Encopresis	☐ Irritability	☐ Sleep Difficulties
☐ Anorexia	☐ Excessive sleepiness	☐ Lying	☐ Sneaky
☐ Animal abuse	☐ Excessive Worries	☐ Nightmares	☐ Stealing
☐ Anxiety	☐ Explosive Behavior	☐ Memory problems	☐ Stomachaches
☐ Attachment	☐ Failing grades	☐ Manipulative	☐ Suicidal Thoughts
☐ Back Pain	☐ Fainting/dizzy spells	☐ Overactive	☐ Tantrums
☐ Bed-wetting	☐ Fears	☐ Overeating	☐ Truancy
☐ Boredom	☐ Fidgety	☐ Panic symptoms	☐ Unusual Habits
☐ Bowel disturbances	☐ Financial Problems	☐ Physical pain	☐ Victim-Emotional
☐ Compulsiveness	☐ Fighting	☐ Premature	☐ Victim Physical Abuse
☐ Concentration issues	☐ Fire setting	☐ Resentful	☐ Victim-Sexual Abuse
☐ Distracted	☐ Hairpulling	☐ Restlessness	☐ Victim-Verbal Abuse
☐ Deceitfulness	☐ Headaches	☐ Running away	☐ Victim-Violent Crime
☐ Depression	☐ Hyperactive	☐ School/Work Problems	☐ Immature
☐ Defiant	☐ Identity issues	☐ Sensory issues	☐ Sexual Problems
☐ Drug abuse	☐ Other:		

Has client ever experienced abuse? ☐Yes ☐No If yes, explain:

Does client have any past or current trauma(s)? ☐Yes ☐No If yes, explain:

Has client ever caused harm to another person physically or emotionally? ☐Yes ☐No If yes, explain:

Has client experienced any recent changes/losses? ☐Yes ☐No If yes, explain:

SUBSTANCE USE HISTORY

☐ SUBSTANCE USE IS NOT APPLICABLE TO CLIENT

Cutting Back	Have you ever cut down or tried to cut down on your alcohol or drug use (or gambling, etc)?	☐Yes	☐No
Annoyance	Do you ever feel annoyed when others complain about your drinking or drug use (your gambling, etc.)?	☐Yes	☐No
Guilt	Do you ever feel bad or guilty about your use of alcohol or drugs?	☐Yes	☐No
Early Morning use	Do you ever use early in the day to overcome a hangover or other effects of drinking or using drugs the night before?	☐Yes	☐No

ALCOHOL & DRUGS

TYPE OF ALCOHOL	AGE 1ST USE	DAYS USED IN LAST 30 DAYS	AMOUNT	FREQUENCY

TYPE OF DRUG	AGE 1ST USE	DAYS USED IN LAST 30 DAYS	AMOUNT	FREQUENCY	ROUTE OF ADMINISTRATION

SOCIOCULTURAL BACKGROUND

ETHNICITY/CULTURE/SPIRITUALITY

☐ Hispanic ☐ American Indian ☐ Asian ☐ African American ☐ Pacific Islander ☐ White ☐ Other:_____

Role of religious/spiritual(s)/value(s) in childhood? ☐Yes ☐No If yes, please explain:

Role of religious/spiritual(s)/value(s) now? ☐Yes ☐No If yes, please explain:

Does client have a faith system/spirituality/religious preference? ☐Yes ☐No If yes, please explain:

If yes, is he/she actively involved? ☐Yes ☐No If yes, please explain:

Does client have a current place of worship/church? ☐Yes ☐No If yes, list place of worship/church:

EMPLOYMENT & OCCUPATIONAL STATUS

☐ Full-Time ☐ Part-Time ☐ Student ☐ Other:_____

Job Title:	Employer:	How long at current job?

Level of Present Occupation Satisfaction? ☐ HIGH ☐AVERAGE ☐ LOW ☐ VERY LOW

LEGAL INFORMATION

Please list any legal issues that are affecting the client or client's family at present, or have had a significant effect upon client in the past.

PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Are you presently receiving, or have you ever had any psychiatric/psychological care or counseling? ☐Yes ☐No

DATE OF Tx	DIAGNOSIS(S)	CLINIC/AGENCY	PROVIDER NAME	TYPE OF Tx (e.g.Outpatient)	RESPONSE TO Tx

Does (has) any other family members have (had) any psychiatric treatment? ☐Yes ☐No If yes, explain:

Has client had any prior suicidal attempts? ☐Yes ☐No If yes, explain:

Does client have any current suicidality/suicidal ideation? ☐Yes ☐No If yes, explain:

Has client had any incident (s) involving self-harm? ☐Yes ☐No If yes, explain:

Are there any guns in client's residence? ☐Yes ☐No If yes, where are they kept?

MEDICAL HISTORY

In your opinion, what is the state of client's health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PERSONAL (FAMILY) PHYSICIAN: | PHONE NUMBER:

May we contact him/her for collateral information? ☐Yes ☐No **If yes, please fill out the release of information form.**

Is client presently receiving medical treatment? ☐Yes ☐No If yes, please list:

Does client have any significant health problems or injuries that have been treated in the past? ☐Yes ☐No If yes, please list:

Does client have any history of the following:

Hospitalization ☐ Yes ☐ No If yes, explain: | **Head Injury** ☐ Yes ☐ No If yes, explain:

Major Accident ☐ Yes ☐ No If yes, explain: | **Loss Consciousness** ☐ Yes ☐ No If yes, explain:

Seizures ☐ Yes ☐ No If yes, explain: | **Current Pain** If yes, rate pain 1-10: 1-2-3-4-5-6-7-8-9-10

List any known allergies or any allergic reactions to medications:

MEDICATIONS

Medication	Dosage	Frequency	Prescriber

ADDITIONAL INFORMATION

In your own words what do you see as client's strengths and challenges:

Strengths:

Challenges:

Who is in client's support system?

On a scale of 1 (low) to 10 (high), how would you rate client's current functioning?

1 2 3 4 5 6 7 8 9 10

On a scale of 1 (mild) to 10 (totally impacting), how would you rate the severity of client's issues?

1 2 3 4 5 6 7 8 9 10

What does client hope to accomplish in treatment?

CLIENT SIGNATURE		DATE SIGNED
PARENT/GUARDIAN SIGNATURE - If client is under 18	RELATIONSHIP TO CLIENT	DATE SIGNED