BreakThru
Counseling and Consulting, P.C.

Child/Adolescent Intake Information

Please provide the following information. The highest standards of professional confidentiality will be maintained.

PLEASE PRINT IN INK:
Child's Last Name ________________ First Name ________________ Middle Name ________________
Address ____
City ________________________________ State ______________ Zip Code ____________________
Home Phone # ________________Work Phone # ________________Cell Phone#__________________
Sex: __Male __Female Date of Birth ___________ Age _____ Race_________________________
Ethnicity/Culture: ______________________ __Adopted __ Natural __ Foster __ Step-child
U.S. Citizen? Y N If No, Explain Status: ____
Name of person responsible for payment ____
Relationship to child ____
Address (if different from child) ____
Place of employment ____
Telephone Numbers: Home _____________ Business ______________Cell______________________
OK to leave a voicemail at Home # Yes No Work # Yes No Cell# Yes No OK to Text Cell? ____

We need to alert you if you choose to communicate with us by electronic transmission (faxes, cell phone, and/or emails), that, in this day and age of hackers, there is no 100% guarantee of confidentiality for any of us via electronic transmission. Thus, privacy of electronic transmissions cannot be assured. If you indicate on this form that you are "OK" for BreakThru to contact you via cell phone, text, and/or email your signature below serves as your agreement to assume the risks to client confidentiality involved with any electronic communication. However, we'll do our utmost to preserve your confidentiality on our end.

Family member to notify in case of emergency: _______________________________________
Their address ____ Relationship _________________
City __________________________________ State _______________ Zip Code __________________
Home Phone # _______________Work Phone # _________________Cell#_________________________

The information requested below will be helpful in understanding your child. Feel free to add as much information as you think will be helpful in understanding the background and nature of the problem(s).

PLEASE DESCRIBE THE PROBLEM WHICH PROMPTED YOU TO SEEK COUNSELING. If possible, list questions for which answers are being sought. _____________________________________
____
____
____
____

Have there been previous psychological, psychiatric, neurological, or school evaluations? __Yes __No
If so, please list names, addresses, and dates of contact. _____________________________________
____
____

Has your child had any previous mental health counseling or has he/she been in a psychiatric in-patient facility before? __Yes __No
If yes, list names, addresses, and dates of contact. ____
____
____

Please list all people now living in the household; then draw a line and list others who have lived there during the child's lifetime.

	Name	*Relationship to Child*	*Age*	*Highest School Grade*	*Occupation*
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Has any member of the immediate family experienced any of the following in the past five years?
__Adoption __Death __Chronic illness of loved one __Unemployment __Job Changes
__Family moves __Divorce __ Addiction __Other life trauma or Stressor

Please explain with approximate dates: ____
____
____
____
____

MEDICAL HISTORY: List major illnesses, operations and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time your child was unconscious, had convulsions, was delirious, or had a very high fever. ____
____
____
Is your child currently taking any medication? __ Yes __ No Describe type and reason: ______
____
Allergies? ____
How is the child's vision? ____
How is the child's hearing? ____
Describe speech and/or hearing problems and therapy: ______________________________________
____
Describe any problems with awkwardness or clumsiness: _____________________________________
____
When did your child last have a physical examination? ______________________________________
Name of physician ____
Address ____
City ___________________________ State ________ Zip code __________ Phone # ________________

Were there any problems in attaining early developmental milestones (such as learning to walk or talk)?
__Yes __No If so, please describe. ____
____

Any other significant experience or influence on your child's early development? ____________________
____

CURRENT FUNCTIONING AND HABITS:

Describe your child's appetite and eating habits at present. ______________________________________
____

Describe nervous habits such as hair pulling, nail biting, hurting self, etc. ___________________________
____

Describe any (other) habits or behavior which concern you (such as use of alcohol or other drugs, smoking, cursing, shoplifting, obsessive worry, etc.) ____
____
____

Describe child's sleeping pattern now. Are there nightmares or night terrors now or in the past? _______
____

Describe child's level of activity and vigor. ____
____

Describe your method of discipline and how your child reacts to such discipline. ____________________
____
____

How does your child get along with other children in the family? ________________________________
____

How does your child get along with others his/her age? A leader? Follower? Associates with others who are older? Younger? ____
____
____
____

Describe any moody periods. ____
____
____

Describe any problems in sitting still/concentrating/distractibility. ________________________________
____
____

Describe what your child likes to do for fun, special interests, hobbies, etc. ________________________
____
____

Describe pattern of interaction with opposite sex, including dating history and any concerns about sexual activity or identity. ____
____
____

PROBLEM AREAS:

In the following list, please place a check mark next to each item which identifies an area of concern about your child. Place an "X" by those items which most concern you.

_____Abuse Issues: Emotional Physical Sexual
_____Violence to animals, property, others
_____Anger
_____Depression
_____Eating difficulties
_____Education
_____Fearfulness/Anxiety
_____Legal issues/charges
_____Problems in relationships with the opposite sex
_____Problems with siblings
_____Problems with peers
_____Religious/Spiritual issues
_____Sexual concerns
_____Obsessions/Compulsions
_____Perfectionism

_____Self Esteem
_____Sleep patterns
_____Thoughts of hurting others
_____Trouble making decisions
_____Thoughts of suicide
_____Problems with Parents
_____Use of alcohol / drugs
_____Use of alcohol and/or drugs by a family member
_____Pornography
_____Use of tobacco
_____Work
_____Physical Problems
_____Physically hurting self
_____Other Specify ______________________

EDUCATIONAL HISTORY:

Name of school ____ Grade ____________
School counselor or principal, if known ____
School phone number if known ____
(We will not contact the school without a separate, signed release of information)
List previous schools attended with dates ____
____
____
Has the child ever repeated a grade:__Yes __No If so, when and why?_________________________
____
How have teachers or other professionals described your child's problems? _________________________
____
What are the child's grades like now? ____
____
Describe any difficulties in learning in school. ____
____
Have there been any behavior problems or disciplinary action at school? __Yes __No
If so, please describe ____
____
Is your child now or ever been in any special education programs? __Yes __No
If so, please describe ____
____

RELIGIOUS BACKGROUND:

Describe child's religious experience (religious affiliation, denomination, member of a church, attendance in Sunday School and worship services, religious training at home, prayer life, concept of God, etc.)
____
____
____
____

LEGAL BACKGROUND:

Has your child ever been in any legal trouble? __Yes __No
If so, please describe ____
____

CUSTODY INFORMATION: Sometimes a child/teen has several adults and/or agencies sharing custody and/or care of the child/teen. If there has been a divorce, adoption or other event to effect custody of the child/teen, please complete the following:

Who has legal custody of the child/teen? (List all involved when custody is being shared)
____
____
____
Give names of biological parents. Describe level of involvement each parent has currently with the child/teen.
____
____
____

Who has physical custody of the child/teen (i.e., who does the child live with)? ____________________
____

Step parent(s) names (list all) ____
____
____
____

Adoptive or Foster parent(s) (circle one) – name(s): ____
Address: ____
Phone #: ____

Is the Department of Family & Children Services involved with the child/teen? __Yes __No
If so, list the name and phone number of social worker: ____
____

Describe any visitation arrangements/agreement in place? ____
____
____

Describe child/teen adjustment to current home placement: _______________________________________
____
____

If child/teen was removed from biological parent(s) home, describe the reason/circumstances under which the child/teen was removed ____
____
____

Is custody or visitation of the child/teen being disputed? __Yes __No
If so, please explain ____
____
____

If someone other than the legal guardian is bringing the child/teen to counseling, a written and notarized consent to treat from the legal guardian is required before counseling can begin. If divorced, written proof of legal custody of child is required.

My signature below serves as my acknowledgement that the above information I've given is accurate and that I accept the risks to client confidentiality by choosing to engage in electronic communication with BreakThru Counseling and Consulting, P.C.

_____________________________________ _____________________________________
Parent/Legal Guardian Relationship to the child client

Date ___________

____
Witness

Date __________