GHP Counseling Services
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Child/Adolescent Intake Form

Thank you for taking the time to fill out this intake form. Please complete all items if possible. If you have any questions, please ask.

I. Identification Information

Today's Date: _____

Your Name: _____ Relationship to Child: _____

Child's full name: _____

Child's date of birth: _____ Current Age: _____ Gender: M ___ F_____

Home Address: _____
Street City State Zip Code

Home Phone Number: _____ Cell Phone Number: _____

Mother's Name: _____Email _____

Father's Name: _____Email _____

Legal Guardian: _____ Email _____

Married status of biological parents (please check one): ☐ Married ☐ Never Married

☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

May I contact and leave detailed voice messages? ___ Y ___ N

When are the best days and times to reach you? _____

Primary E-mail address for parent/guardian: _____

Permission to contact via e-mail: ___ Y ___ N

Primary Phone Number: _____ Alternate Phone Number: _____

May I contact and leave detailed voice messages? ___ Y ___ N

When are the best days and times to reach you? _____

II. Chief Concerns:

What concerns or issues convinced you to seek attention now? _____
_____
_____
_____

What do you think causes the problem? _____
_____
_____

What have you done to try and address the problem(s)?
_____
_____
_____

Please check the issues for which you are seeking treatment:

_____ Depression _____ Anxiety _____ Relationship Issues

_____ Suicidal Thinking _____ Anger Problems _____ Parenting Issues

_____ Grief & Loss Issues _____ Guilt _____ Sexual Issues

_____ Alcohol/Drug Use _____ Divorce/Separation concerns _____ Medical Issues

_____ Work Issues _____ School Problems _____ Legal Issues

_____ Other: _____

Please describe in your own words the primary issue(s) for which you are seeking counseling for your child/adolescent: _____
_____
_____

How long has/have the current problem(s) existed? _____

How frequently do these problems occur? _____

Have these problems gotten worse since they began?: _____yes _____no

Are these problems present at: _____Home _____School _____Work _____W/ Others

Client Name:_____ Client ID:_____

Have these problems ever decreased or gone away?: _____yes _____no

If yes, please describe: _____

_____

_____

What, if anything, have you done to cope with the problems for which you are seeking help?
_____

_____

_____

I. Current Problem Description:

Please check the **behaviors** which **currently** apply to your child:

_____Frequent Crying _____Hyperactive Behavior

_____Self-Neglect _____Working Too Much

_____Loss Of Interest In Previously Enjoyable Activities _____Temper Outbursts

_____Trouble Concentrating _____Drinking

_____Withdrawing From Others _____Drug Misuse

_____Eating Too Much _____Eating Too Little

_____Purging _____Skipping Meals

_____Sleeping Too Much _____Trouble Falling Asleep

_____Trouble Staying Asleep _____Nightmares

_____Flashbacks _____Cutting/Self-Mutilation

_____Other:_____

Please check the **feelings** which **currently** apply to your child:

_____Restless _____Sad _____Lonely _____Worthless

_____Nervous _____Confused _____Overwhelmed/Stressed

_____Helpless _____Moody _____Like A Failure

_____Angry _____Distrustful _____Ashamed

_____Panicky _____Unattractive _____Fearful

_____Irritable _____Annoyed _____Unmotivated _____Other

Please check the **physical symptoms** which **currently** apply to your child:

_____Stomachaches _____Racing Thoughts _____ Numbness/Tingling

_____Headaches _____Dizziness _____Loss of Sex Drive

_____Back Pain _____Heart Pounding _____Appetite Changes

_____Tremors/Shakiness _____Chest Pain _____Weight Loss/Gain

_____Fainting Spells _____Blackouts _____Other:_____

II. Medical History:

With a score of 1 being *poor* and 10 being *excellent*, how would you rate your child's current health?: 1 2 3 4 5 6 7 8 9 10

Do you currently have a primary physician? ___ Y ___ N

If yes, whom? _____

Date of last physical exam? _____

Are they currently taking medication? ___ Y ___ N

Medication	Taken For	Date Begun	Dosage	Frequency	Prescribing Doctor

Client Name:_____ Client ID:_____

Are they **currently** being treated for any medical problems/issues?: _____yes _____no

If yes, explain: _____
_____

III. Behavioral Health History:

Are they **currently** being seen by a psychiatrist?: _____yes _____no

If yes, name of provider/facility_____

Location:_____

Frequency:_____

Reason:_____

Date of Last Visit:_____

Are they **currently** attending any mental health counseling?: _____yes _____no

If yes, name of provider/agency:_____

Location:_____

Frequency:_____

Reason:_____

Date of Last Visit:_____

Have they received counseling and/or psychiatric treatment in the past?: _____yes _____no

Dates of Treatment	Name of Provider/Facility	Type of Counseling (individual, group, etc)	Inpatient or Outpatient ?	Reason for treatment?	Did you complete treatment?

Client Name:_____ Client ID:_____

Have any family members ever experienced a mental illness? ___ Y ___ N

If yes, please explain: _____
_____
_____

Do they **currently have** or have they **recently had** thoughts about harming self or committing suicide? ___ Y ___ N

If yes, describe:_____

Have they ever attempted suicide? ___ Y ___ N

If yes, how/when? _____

Did this require medical treatment? ___ Y ___ N

Do they **currently have** or have they **recently had** thoughts of harming another? ___ Y ___ N

If yes, describe: _____

Have they ever attempted to harm another? ___ Y ___ N

If yes, how?:_____

IV. Substance Use History:

Have they ever used tobacco? ___ Y ___ N

If yes, type(s) used _____

How often do they use tobacco?:_____

Age of first use:_____ Age of regular use: _____ When was last use?:_____

Have they ever used alcohol? ___ Y ___ N

If yes, type(s) used:_____

How often do they use alcohol?:_____

Client Name:_____ Client ID:_____

Age of first use:_____ Age of regular use: _____ When was last use?:_____

Have you ever used mood altering drugs (marijuana, cocaine, crack, etc? ___ Y ___ N

If yes, type(s) used: _____

How often do they use them? _____

Age of first use: _____ Age of regular use: _____ Last time used? _____

Has your drug use ever caused you problems? ___ Y ___ N

If yes, explain:_____

VII. Current Family/Relationship Information:

Please check the option that best reflects the parent's current relationship status.
_____Never married and not currently in a serious relationship
_____Never married but in a serious relationship
_____Currently married and living with spouse
_____Currently married but separated from spouse
_____Currently divorced and single
_____Currently divorced but in a serious relationship
_____Currently widowed and single
_____Currently widowed but in a serious relationship

Please list the name, age, parents' names and city/state of residence for each of your children: Also, please list anyone else (excluding the children listed) whom they consider to be a source of social/emotional support for them. Please indicate whether they currently live with them and/or their relationship.

Child's Name	**Child's Age**	**Parents' Names**	**Child's Current City/State of Residence**

Client Name:_____ Client ID:_____

Do they **currently feel safe** at home? ___ Y ___ N

Has the child experienced or been exposed to any known physical, emotional, sexual abuse or neglect? Y ____ N ____ (If so please explain situation(s)):_____
_____
_____
_____
_____
_____ (*please continue on the back of page if needed*).

VIII. Your Family of Origin:

Who primarily raised them?:_____

What is his or her/their relationship with them?:_____

Are there significant changes growing up, such as the death of a loved one, a divorce, or separation from a primary caregiver, please describe these changes and list how old they were when they occurred: _____
_____
_____

Do they have brothers and/or sisters? ___ Y ___ N

If yes, # of brothers: _____ # of sisters: _____

# of half-brothers: _____ # of half-sisters _____

# of step-brothers: _____ # of step-sisters: _____

Has there ever been a time **when adults who were supposed to be taking care of them did not?** ___ Y ___ N

Growing up, did **parents or caregiver call them names or put them down?** ___ Y ___ N

Has a **family member or caregiver** ever **threatened to physically harm them?** ___ Y ___ N

Have they ever been **hit, kicked, shoved, strangled, or otherwise physically harmed by a family member or caregiver?** ___ Y ___ N

Have there been issues of **bullying** at home, on-line, school or other settings? ___ Y ___ N
If so where? _____

Client Name:_____ Client ID:_____

Are parents, close relatives or family friends currently in the military or served in the military? ___ Y ___ N

Were parents, close relatives, or family friends ever deployed in forward operations or other hostile environments (to include combat, forward support operations or other? ___ Y ___ N

XI. Your Strengths, Weaknesses, and Treatment Goals and Preferences:

Please list any strengths: _____

Please list any weaknesses:_____

I hope counseling will help them:_____
_____

Are there any preferences for treatment, such as preferred days, appointment times, or treatment activities? _____

_____

Any additional information you wish to share? _____

Please list desired goals for counseling
1) _____

2) _____

3) _____

4) _____

Client Name:_____ Client ID:_____