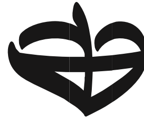

Inner Peace
Coaching & Counseling

CHILD & ADOLESCENT COUNSELING INTAKE

General Information:

Print Client's Name: ______________________________ DOB:______________
Date of Intake Appt.:______________ Religious affiliation: ______________
School & System ______________________________ Grade ______________

Responsible Party:

As the parent/guardian initiating counseling (by completing the "Child & Adolescent Counseling Intake Form"), did you bring the original (not a copy) legal document filed with the courthouse (e.g. custody papers w/original signatures and court's stamp/seal) which states you have legal authority to initiate medical treatment (e.g. counseling/therapy)? □ Yes □ No □ Not Applicable

Did the responsible party/parent(s)/guardian(s) and client (if age 12 or older) have the opportunity to ask questions before signing the Inner Peace Coaching & Counseling "Informed Consent" form? □ Yes □ No

Did you receive a copy of the "Informed Consent" form for your records? □ Yes □ No

Child/Adolescent's Counseling History, Needs & Goals:

What are the problems or difficulties your child is experiencing? ______________________________
____
____

What are the primary goals/outcomes you want to see as a result of counseling? ______________________________
____
____

Have you ever gone to a Social Service Agency (i.e., Court, Department of Health & Human Resources, Community Service Agency)? ______________________________

Who referred you here? ______________________________ Position ______________

Address/Phone: ______________________________

Is counseling mandated? □ Yes □ No

Please tell me about your child's previous counseling experience(s):

Provider	Where	When	How long	Useful?
____________	____________	________	________	□ Yes □ No
____________	____________	________	________	□ Yes □ No

Clinician's Notes: (Client, please do not complete this section.)

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Problem Behaviors & Strengths Checklist: Circle all which apply to your child.

Shy	Lacks self-confidence	Over-sensitive
Demands attention	Been in trouble with juvenile authorities	Takes things that are not his/hers
Disobeys mother	Cries easily	Has sleeping difficulties
Disobeys father	Is irritable	Is nervous and jumpy
Shows immature behavior	Gets along poorly with brothers & sisters	Feels unhappy
Is fearful	Truancy	Is stubborn
Soils himself/herself	Bedwetting	Is bossy
Temper tantrums	Is destructive	Misbehaves at home
Is overactive	Refuses to share	Misbehaves at school
Has guilt feelings	Nightmares	Headaches
Nail biting	Eating problems	Doesn't tell the truth
Sex problems	Complains about going to school	Sucks thumb
Fears and phobias	Is cruel to animals or pets	Is messy
Over-dependency	Has morbid preoccupations (death, etc.)	Is easily frustrated
Jealousy resentment	Shows unusual interest in fires	Is overly suspicious
Cruelty	Is afraid to defend him/herself	Can ask for help
Does not show feelings	Has suicidal thoughts/behaviors/attempt(s)	Can calm him/herself
Has an allowance	Alcohol/Drug/Substance Use/Abuse	Has friends
Has a curfew	Intentionally harms own body	Can forgive
Has self-control	Has bizarre or unusual behavior	Sense of humor
Motivated	Is overly concerned about neatness	Has responsibilities at the house
Patient	Shows compassion & empathy for others	Accepts love & care from others

Other: ____

Clinician's Notes: (Client, please do not complete this section.)

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Family Information & History:

Father ____________________________________Age ______ Employer _____________________________________
Work Phone _______________________________________ Occupation ______________________________________
Mother ___________________________________Age ______ Employer ______________________________________
Work Phone _____________________________________ Occupation ______________________________________
Did parents ever marry? □Yes □No If yes, did they separate/divorce? □Yes □No If so, when? _____________________
Siblings (Circle those living in the home):

Name	Age	M/F	Name	Age	M/F

Others living in the home (include age and relationship): ____

____

Please circle any of the following which have appeared in a family member other than the client:

Reading Disorder	Birth Defect	Vision Problems	Learning Problems
Cerebral Palsy	Allergies	Mental Retardation	Neurological Problems
Emotional Problems	Epilepsy	Migraine Headaches	Hearing Problems

Other ____

Have you ever sought Mental Health Assistance for anyone else in your family? □ Yes □ No If so, when and where?

____

Have there been any serious medical problems in other members of the family? □ Yes □ No
Have the child's parents ever been married to each other? □ Yes □ No If yes, how long? _____________________
Are there any marriage problems between the parents? □ No □ Yes ______________________________________
If the child's parents do not live together, does the child get to see both parents? □ Yes □ No
If so, how regularly? ____
Have there been any deaths in the immediate family? □ Yes □ No
If so, when did this occur, and what was the cause of death? ____
Is there anything else you would like the therapist to know about your family situation? _________________________

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Clinician's Notes: (Client, please do not complete this section.)

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School History:

Did your child attend nursery school? □ Yes □ No If so, how many years? ________________________________
Does your child like school? □ Yes □ No Teachers? □ Yes □ No Classmates? □ Yes □ No
Has your child frequently been absent from school? □ Yes □ No If so, why? ______________________________
Best school subject(s): ______________________________ Easiest subject(s) ______________________________
Hardest subject(s): _________________________________ Favorite subject(s) _____________________________

Any grade(s) repeated?	□ Yes	□ No	Remedial work or tutoring?	□ Yes	□ No
Does your child like to read?	□ Yes	□ No	Be read to?	□ Yes	□ No
Does your child show interest in art?	□ Yes	□ No	Music?	□ Yes	□ No

Does your child show interest in other areas (i.e., sports, drama, hobbies)? ____

Do you feel that your child is working up to potential? ☐ Yes ☐ No ____

Please state any school-related problems or difficulties: ____

General Behavior:

What problems does your child have at home? ____

Does your child have difficulty relating to family? ____

Does your child have difficulty relating to his/her teachers? ____

Does your child have difficulty relating to his/her peer group? ____

How does your child compare with your other children? ____

What medications, if any, have been used to help with your child's behavior? ____

Clinician's Notes: (Client, please do not complete this section.)

Biomedical History:

Were there any birth difficulties and/or injuries? ____

Length of pregnancy: ________________ Discoloration? ________________

Birth Weight: ____________ Lack of oxygen? ____________ Condition of newborn? ____________

Age of: Walking ____________ Talking ____________ Toilet Training ____________

What aches, pains, or physical discomfort does this child have? ____

What has he/she been hospitalized for in the past? ____

Has the child had any of the following? If yes, approximate date?

_____ Hyperactivity _____ Seizures _____ Pneumonia _______ Ear Discharge

_____ Convulsions _____ Head Injuries _____ High Fever _______ Allergies

_____ Earache _____ Dizziness _____ Feeding Problems _______ Hearing Problems

_____ Other: ____

Has the child had an accident or hard fall? ____

What medication, if any, is he/she currently taking? ____

When and where was the child's last:
Vision Exam ____________ ____________________________ Results: ____
Hearing Exam ___________ ____________________________ Results: ____
Speech Exam ____________ ____________________________ Results: ____
Child/Adolescent's Primary Care Physician: ____
Address: ____
Date of last physical examination? ____

Clinician's Notes: (Client, please do not complete this section.)

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Parental Impressions:

Do you think your child has an emotional or learning problem? ____
Would it embarrass you if your child has an emotional or learning problem? _____________________________________
Do both parents agree that there are problems? ____
Do you feel, in part, responsible for your child's problems? ____
What concerns you most about him/her? ____
____
At this point, what solutions to your difficulties have you considered? ____
____
Who originated the idea of coming to this facility? ____
Do you feel that your child would be helped more by:
Talking about his/her problems individually? ____
A directed program to change specific behaviors? ____
Psychological or Learning Disability Testing? ____
Counseling with Teachers? ____
Group therapy? ____
Receiving medication? ____
Counseling with parent(s)/guardian(s)? ____
Play therapy? ____
Other (specify)? ____

Clinician's Notes: (Client, please do not complete this section.)

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Additional Information:

In the space below, please provide any other significant or interesting facts about this child that may not have been asked about.

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Clinician's Notes: (Client, please do not complete this section.)

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Dear Client/Parent(s)/Guardian(s):

Thank you for completing this form. Please bring it with you to your child's/adolescent's initial appointment.