New Beginnings
HEALTH AND WELLNESS

# CHILD & ADOLESCENT INTAKE

Name: _____
DOB: _____
Chart #: _____
MID/Ins #: _____
MID/Ins #: _____

## CLIENT INFORMATION

**DATE** _____

| First Name | Middle Name | Last Name | | |
|---|---|---|---|---|
| Address | City | State | Zip | County |
| Home Phone | Cell Phone | Work Phone | | |
| Date of Birth / Age | Sex: ☐ Male Female Other | Preferred Language: | | |
| Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Morethanone race ☐ Native Hawaiian Pacific Islander ☐ White ☐ Decline to report | Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Decline to report | | | |

## INSURANCE INFORMATION

**Primary Insurance Name:** (Copy of Insurance Card/s Required)

| | **Secondary Insurance Name:** |
|---|---|
| Subscriber Name Date of Birth | Subscriber Name Date of Birth |
| Subscriber's Address | Subscriber's Address |
| Subscriber's Telephone # | Subscriber's Telephone # |
| Client's Relationship to Insured ☐ Spouse ☐ Partner ☐ Child ☐ Self | Client's Relationship to Insured ☐ Spouse ☐ Partner ☐ Child ☐ Self |
| Subscriber ID # Group ID # | Subscriber ID # Group ID # |

Emergency or imminent risk contact:
Name: _____ Telephone# _____ Relationship:_____

How did you hear about us? ___ Yellow Pages ___ Attorney: _____
___ Friend/Client ___ Doctor: _____
___ Internet ___ Other agency: _____
___ Court-ordered ___ Other: _____

Crossroads offers appointment reminders. Check below all the ways you wish to receive a reminder.

☐ To Be Called Telephone Number _____
☐ Text Message Text Number _____
☐ Emailed Email Address _____

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Individuals participating in assessment: _____

**Responsible Party Information**

Responsible Party Name _____ Relationship to Client _____
Responsible Party Address _____
What is the best way to contact responsible party? _____
Current custody status: ___ Parents ___ Sole Parental Custody ___ Joint Legal Custody
___ Other: _____ ___ DSS Custody
List all persons who may be bringing this child to therapy sessions _____
_____

**Household Information**

Client's current living situation:
___ At home with parents/guardians ___ With other family ___ Foster care
___ Residential placement ___ Other (explain) _____

List all members of the household:

| Name | Relationship to Client | Age |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List any other significant family members who do not live with client: _____
_____

**Social/Family Information**

Spiritual preference _____
List any support systems: _____
Normal bedtime: _____
Number of hours usually slept: _____ Where does your child sleep? _____ How is your child usually disciplined? _____ What is your child's diet like? _____ Our household is usually (check all that apply)

___ Quiet ___ Calm ___ Highly structured ___ Lots of conflict
___ Noisy ___ Active/Busy ___ More relaxed/unstructured ___ Tense

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What activities does your child enjoy?

___ Video games ___ Telephone ___ Sports
___ TV /Movies ___ Reading ___ Shopping
___ Internet/computer ___ Art/Crafts ___ Playing outside
___ Being with friends ___ Playing with toys ___ Other _____

Is there anything else you would like for us to know about your child's home life? _____
_____

## School Information

School Name _____
Teacher Name(s) _____
Grade Level _____ Academic Performance: ___ Excellent; ___ Good; ___ Fair; ___ Poor; ___ Failing
Behavior in school: ___ Excellent; ___ Good; ___ Fair; ___ Poor; ___ Failing
Special Education Accommodations in place? (e.g. IEP, 504 plans, EC) ___ No___ Yes
(explain:) _____

## Developmental History

Was your child: ___Planned ___ Breast Fed ___ In Day Care
___Unplanned ___ Bottle Fed ___ Kept at Home
___Exposed to medications/drugs/alcohol in the womb
___Difficult or high-risk pregnancy or delivery

At what age did your child:Talk _____ Walk _____ Potty Train _____
Describe any developmentaldelays _____
_____

## Medical History

Has your child experienced any of the following? (If yes, explain.)

___ Childhood trauma _____
___ Severe illness, injury, surgery _____
___ Allergies (foods, drugs, substances) _____
___ Chronic medical problems _____
___ Significant family medical history _____
___ Significant family mental health history _____
___ Significant family substance history _____
___ Prior mental health diagnosis _____
___ Prior developmental diagnosis _____

Primary care physician _____

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MID/Ins #: _____

Currentmedications Name Dosage

_____ _____
_____
_____
_____

Pharmacy Name _____ Telephone # _____
Address _____

## Substance Use History

Alcohol _____
Illegal Drugs _____
Prescription Drugs _____
Smoking Non-Smoker Current Smoker □Ex-Smoker Smokeless Tobacco
Other _____

## Mental Health Treatment History

List all mental health treatment orhospitalizations:

| Facility/Therapist | Purpose | Current | Past |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Response to Treatment: _____

Other agency services/relationships in the last six months:

___ Child Protective Services ___ Justice System ___ Outpatient Mental Health
___ Other DSS Services ___ Disability/Social Security ___ Outpatient Substance Abuse
___ Occupational Therapy ___ Speech therapy ___ Other: _____

## Current Treatment Focus

What brings you and yourchild to our office today? _____
_____
_____
_____

What services are you seeking?

___ Individual Therapy ___ Psychological/Educational Testing
___ Family Therapy ___ Psychiatric Services or Medication Management
___ Other (explain): _____

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I/we would like to address the following: (check all that apply)

___ My child's mood or emotional state
___ My child's school performance
___ My child's cognitive/mental functioning
___ Parenting
___ Divorce
___ Abuse or neglect
___ Grief / Loss
___ My child's behavior
___ My child's sleep, eating, or physical concerns
___ My child's relationships with family or peers
___ Family relationships
___ Cultural adjustment issues
___ Other: _____

---

**Child Assessment:** Check all the following that currently apply to your child.
Indicate past concerns with the letter "P".

_____ Anxiety
_____ Depressed mood
_____ Panic attacks
_____ Racing thoughts or speech
_____ Obsessions/Compulsions
_____ Excessive fears or phobias
_____ Dissociative states
_____ Touchy/irritable
_____ Nightmares
_____ Sleep problems
_____ Bedwetting or incontinence
_____ Tantrums or "meltdowns"
_____ Difficult to parent
_____ Conflicting parenting styles
_____ Parental marital problems
_____ Adopted or in foster care
_____ Lots of physical complaints
_____ Addictions
_____ Parent/child conflict
_____ Loss due to death
_____ Hurts others
_____ Lying
_____ Stealing
_____ Destroying property
_____ Defiance
_____ Blames others for mistakes
_____ Angry/resentful
_____ Lack of conscience
_____ Bizarre behavior
_____ Clingy
_____ Separation anxiety
_____ Seems to overreact
_____ Parent feels overwhelmed
_____ Argues with adults
_____ Doesn't seem to listen
_____ Seems adultlike or older
_____ Life has been unstable
_____ Sensitive to noise
_____ Social media issues
_____ Loss due to other
_____ Hyperactive
_____ Attention problems
_____ Worries all the time
_____ Impulsive
_____ Low self-esteem
_____ Suicidal thoughts
_____ Suicide attempts
_____ Self-harming
_____ Sexually active / acting out
_____ Difficulty with change
_____ Needs predictability/routine
_____ Unexplainable mood shifts
_____ Running away
_____ Deliberately annoys people
_____ Takes excessive risks
_____ Seems younger than age
_____ Life changes pending
_____ Sensitive to feel of clothing
_____ Staring off / blacking out

*I certify that the information provided above is correct to the best of my knowledge, and that I am authorized to provide such information on behalf of this client.*

_____ _____
Signature of Legally Responsible Person Date