**Shontel Thomas, Christian Counselor and Life Coach**
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# CONFIDENTIAL CHILD/ADOLESCENTS INTAKE FORM

Name:_____ Date of Appointment:_____
Address: _____
_____
Date of Birth: _____ Age: _____ Gender: [ ] Male [ ] Female

Address:_____
Parent's Phone #_____ Mobile: _____
Email : _____

**Emergency Information**
Primary Care Physician: _____ Phone: _____
Name of Emergency Contact: _____ Phone: _____
Relationship to Patient: _____

**PRESENTING COMPLAINT**
*(Please list below the main problems your child is having at this time. You will be asked to give a more detailed description, in person at the initial interview)*
_____
_____
What made you decide to bring your child for counseling at this time?
_____
_____

**CURRENT FUNCTIONING**
Has your child experienced any of the following sleep problems recently?
[ ] Difficulty falling asleep [ ] Nightmares/night terrors
[ ] Waking during the night [ ] Fears at bedtime
[ ] Waking early
Has your child experienced any weight change or problems with appetite recently?
Decreased appetite: [ ] Yes [ ] No
Increased appetite: [ ] Yes [ ] No
Lost weight? [ ] Yes [ ] No Lbs.:_____
Gained weight? [ ] Yes [ ] No Lbs.:_____
Unusual eating habits (describe):
_____
_____

Has your child ever:
Talked about harming self or others? [ ] Yes [ ] No
Had a specific plan for harming self or others? [ ] Yes [ ] No
Made an attempt to harm self or others? [ ] Yes [ ] No
Is this a problem right now (describe): [ ] Yes [ ] No

_____

_____

Please identify any of the following behaviors that would be true about your child:

[ ] Flexible
[ ] Thumb sucking
[ ] Cooperative
[ ] Temper tantrums
[ ] Grasps ideas quickly
[ ] Hardworking
[ ] Uncooperative
[ ] Difficulty with decision making
[ ] Lacks self-control
[ ] Rocking
[ ] [Unusually aggressive
[ ] Creative
[ ] Consistently short attention span
[ ] Overactive
[ ] Unusual sexual behaviors
[ ] Easily influenced by others
[ ] Self-confident
[ ]Frequently tells lies
questions or directions
[ ] Difficulty with organization
[ ] Usually shy or withdrawn
[ ] Changes in sleep patterns
[ ] Outgoing
[ ] Daydreams
[ ] Nightmares
[ ] Excessive fears
[ ] Engages in stealing
[ ] Avoids homework
[ ] Low frustration tolerance
[ ] Lacks motivation
[ ] Soiling
[ ] Bed wetting
[ ] Difficulty with changes in routine
[ ] Needs constant approval/reassurance
[ ] Nail biting
[ ] Gentle/Sensitive
[ ] Pessimistic thinking
[ ] Underactive
[ ] Difficulty telling time
[ ] Doesn't seem to understand
[ ] Difficulty making/keeping friends
[ ]Frequent, sudden mood changes
[ ] Difficulty using numbers
[ ] Other:_____

Parent/Guardian Date

Client(Minor) Date