



Individual Child/Adolescent Intake Form

Child/Adolescent Information

Name: _____ DOB: _____

Address: _____

City/State/Zip Code: _____

Mother of Child: Personal Information

Name: _____ DOB: _____

Address: _____

City/State/Zip Code: _____

Phone (H): _____ Phone (cell): _____

Email: _____ OK to contact via email? _____

Employer: _____ Phone (W): _____

Copy of ID or Drivers License

Father of Child Personal Information

Name: _____ DOB: _____

Address: _____

City/State/Zip Code: _____

Phone (H): _____ Phone (cell): _____

Email: _____ OK to contact via email? _____

Employer: _____ Phone (W): _____

Copy of ID or Drivers License

Step Parent or Guardian of Child Personal Information

Name: _____ DOB: _____

What is your relation to the child: _____

Address: _____

City/State/Zip Code: _____

Phone (H): _____ Phone (cell): _____

Email: _____ OK to contact via email? _____

Employer: _____ Phone (W): _____

Referral Source:

If referred, name of group or person that referred you to counseling: _____

Were you referred directly to The Vine Wellness for counseling? () Yes () No

Annual household income(optional): _____ Currently meeting your bills? () Yes () No

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Phone: 210-490-4419

Family Information

People living in the home:

Name: _____ Age: _____ Relationship: _____
 Name: _____ Age: _____ Relationship: _____
 Name: _____ Age: _____ Relationship: _____
 Name: _____ Age: _____ Relationship: _____
 Name: _____ Age: _____ Relationship: _____
 Name: _____ Age: _____ Relationship: _____
 Name: _____ Age: _____ Relationship: _____

What languages are spoken in the home? _____

How many homes has the child lived in? _____

With whom does the child share a bedroom and/or bed with? _____

Who has legal custody of the child? _____

Relationship Status of the Parent/Guardian filling this out:

Are you currently: () Married () Partnered () Divorced () Single () Widowed How long? _____

If not married, are you currently in a relationship? () Yes () No If yes, how long? _____

In what year were the parents separated, if applicable? _____

Child's Development History

Did the mother of the child receive prenatal health care: () Yes () No

Any birth complications or problems? _____

What was your child's birth weight? _____ Were eating/sleep patterns ____regular ____irregular?

What was your child's approach to new situations? ____ Positive ____ Withdrawn ____ Slow to warm up

What was your child's reaction to new stimuli? ____ Intense ____ Moderate ____ Little ____ None

When trying new things would you describe your child as: ____ Adaptable ____ Slow to adapt
____ Unadaptable

How is your child disciplined in the home? _____

Any current troubles with sleeping? _____

Did/does your child co-sleep with anyone in the home, if so with who? _____

Any speech, hearing, or language difficulties? _____

List all childhood illnesses, hospitalizations, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions:

Special skills and talents of child

List hobbies, sports; recreational, musical, TV and toy preferences; etc.: _____

Education Information

Name of current school: _____ Grade: _____

Name of teacher: _____

How many schools has the child attended in the last 2 years? _____

Describe your child's academic performance over the past school year: _____

Is your child's behavior a problem in school? _____

Does (s)he use Special Education services? _____

If applicable, date of last ARD: _____

Current Health Information

List any chronic illnesses, genetic illnesses, allergies or handicaps: _____

Is your child currently being treated for any illnesses or medical problems? () Yes () No What type? _____

Current Weight _____ Height _____

Is your child taking any medications at this time? () Yes () No

List ALL current prescription medications and how often your child takes them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: _____

Date and place of your child's last yearly check-up: _____

Current Physician: _____

Phone: _____

Family Psychiatric History:

Has anyone in your child's family been diagnosed with or treated for:

- | | |
|------------------------------------|---|
| Bipolar disorder -----()Yes ()No | Schizophrenia -----()Yes ()No |
| Depression -----()Yes ()No | Post-traumatic stress -----()Yes ()No |
| Anxiety -----()Yes ()No | Alcohol abuse -----()Yes ()No |
| Anger -----()Yes ()No | Other substance abuse-----()Yes ()No |
| Suicide----- ()Yes ()No | Violence----- ()Yes ()No |

If yes, who had each problem? _____

Has any family member been treated with a psychiatric medication? () Yes () No

If yes, who was treated, what medications did they take, and how effective was the treatment?

Has a relative ever been **hospitalized** for drug or alcohol use, or mental or emotional difficulties?

Child's Psychiatric History:

Has your child participated in counseling in the past? () Yes () No

Is your child currently involved in any other counseling, including lay counseling, spiritual counseling, counseling at school, and/or professional counseling? () Yes () No

Current or past mental health diagnoses, date of diagnosis and by whom:

Intensive outpatient treatment? () Yes () No If so, When: _____

Where? _____

Psychiatric Hospitalizations? () Yes () No If so, When: _____

Where? _____

Drug and Alcohol Treatment/hospitalizations? () Yes () No If so, When : _____

Where? _____

Caffeine Usage:

How many caffeinated beverages do you drink a day?

Coffee _____ Sodas _____ Tea _____ Energy Drinks

Tobacco History:

Has your child ever smoked cigarettes/E-Cigarettes? () Yes () No

Currently? () Yes () No If so, How often: _____

Has your child used chewing tobacco? () Yes () No

Alcohol and/or drug use:

Does your child drink alcohol? () Yes () No

If Yes, how often? _____

Extra-curricular Activities/ Exercise:

Does your child exercise regularly? () Yes () No

Is your child currently involved in any organized groups/ individual lessons? () Yes () No

If Yes, please list: _____

Trauma History:

Has there been any significant changes in your child's life in the past 18 months? () Yes () No

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If yes, explain: _____

Are you aware if your child has ever experienced any form of abuse: emotional, sexual, physical or by neglect? () Yes () No

If Yes, please describe when, where, by whom and if a CPS report was made _____

Spiritual Life:

Does your child belong to a particular religion or spiritual group? () Yes () No

Name of congregation: _____

If yes, what is the level of your child's involvement?

Do you find your child's involvement helpful during this time, or does the involvement make things more difficult or stressful for them? () more helpful () stressful

Mental Status Information

Has your child made any recent comments about suicide, not wanting to be around any more, or comments/signs of harming themselves in any way?

() Yes () No

Has your child had any thoughts/comments, even once, in the past, including the past few days or weeks, of suicide or harming themselves in any way? () Yes () No

Has your child made comments about harming anyone else in any way? () Yes () No

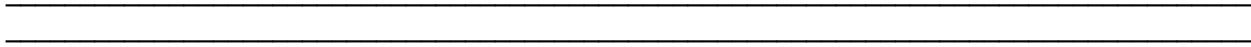
Counseling Information

Describe the situation that brings you to seek counseling for your child: _____

Describe what has already been done to resolve the situation: _____

What do you hope for in resolving the situation? What will be different? _____

Is there anything else that doesn't appear on this or other forms, but that is or might be important?



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