

BreakThru

Counseling and Consulting, P.C.

Child/Adolescent Intake Information

Please provide the following information. The highest standards of professional confidentiality will be maintained.

PLEASE PRINT IN INK:

Child's Last Name _____ First Name _____ Middle Name _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Sex: M F Date of Birth: _____ Age: _____ Race: _____

Ethnicity/Culture: _____ Adopted Natural Foster Stepchild

U.S. Citizen? Y N If No, Explain Status: _____

Name of person responsible for payment _____

Relationship to child _____

Address (if different from child) _____

Place of employment _____

Telephone Numbers: Home _____ Business _____ Cell _____

OK to leave a voicemail at Home: Yes No Work: Yes No Cell: Yes No OK to Text Cell? Yes No

We need to alert you if you choose to communicate with us by electronic transmission (faxes, cell phone, and/or emails), that, in this day and age of hackers, there is no 100% guarantee of confidentiality for any of us via electronic transmission. Thus, privacy of electronic transmissions cannot be assured. If you indicate on this form that you are "OK" for BreakThru to contact you via cell phone, text, and/or email your signature below serves as your agreement to assume the risks to client confidentiality involved with any electronic communication. However, we'll do our utmost to preserve your confidentiality on our end.

Family member to notify in case of emergency: _____

Their address _____ Relationship _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____ Cell#: _____

Please describe the issues/situation that concerns you about this child:

Have there been previous psychological, psychiatric, neurological, or school evaluations? Yes No
If so, please list names, addresses, and dates of contact. _____

Has your child had any previous mental health counseling or has he/she been in a psychiatric in-patient facility before? Yes No
If yes, list names, addresses, and dates of contact.

Please list all people now living in the household; then draw a line and list others who have lived there during the child's lifetime.

	Name	Relationship to Child	Age	Highest School Grade	Occupation
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

Has any member of the immediate family experienced any of the following in the past five years?

Adoption	Death	Chronic illness of loved one	Unemployment	Job Changes
Family moves	Divorce	Addiction	Other life trauma or Stressor	

Please explain with approximate dates: _____

MEDICAL HISTORY: List major illnesses, operations and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time your child was unconscious, had convulsions, was delirious or had a very high fever.

Is your child currently taking any medication? Yes No
Describe type and reason: _____
Allergies? _____
How is the child's vision? _____
How is the child's hearing? _____
Describe speech and/or hearing problems and therapy: _____
Describe any problems with awkwardness or clumsiness: _____

When did your child last have a physical examination? _____
Name of physician _____
Address _____
City _____ State _____ Zip code _____ Phone # _____

Were there any problems in attaining early developmental milestones (such as learning to walk or talk)? Yes No
If so, please describe _____
Any other significant experience or influence on your child's early development? _____

CURRENT FUNCTIONING AND HABITS:

Describe your child's appetite and eating habits at present.

Describe nervous habits such as hair pulling, nail biting, hurting self, etc.

Describe any (other) habits or behavior which concern you (such as use of alcohol or other drugs, smoking, cursing, shoplifting, obsessive worry, etc.)

Describe child's sleeping pattern now. Are there nightmares or night terrors now or in the past?

Describe child's level of activity and vigor. _____
Describe your method of discipline and how your child reacts to such discipline.

How does your child get along with other children in the family?

How does your child get along with others his/her age? A leader? Follower? Associates with others who are older? Younger?

Describe any moody periods.

Describe any problems in sitting still/concentrating/distractibility.

Describe what your child likes to do for fun, special interests, hobbies, etc.

Describe pattern of interaction with opposite sex, including dating history and any concerns about sexual activity or identity.

PROBLEM AREAS:

In the following list, please place an "X" next to each item which identifies an area of concern about your child. Place 2 "X"s by those items which most concern you.

- | | |
|--|---|
| <input type="checkbox"/> Abuse Issues: Emotional Physical Sexual | <input type="checkbox"/> Self Esteem |
| <input type="checkbox"/> Violence to animals, property, others | <input type="checkbox"/> Sleep patterns |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Thoughts of hurting others |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Trouble making decisions |
| <input type="checkbox"/> Eating difficulties | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Education | <input type="checkbox"/> Problems with Parents |
| <input type="checkbox"/> Fearfulness/Anxiety | <input type="checkbox"/> Use of alcohol / drugs |
| <input type="checkbox"/> Legal issues/charges | <input type="checkbox"/> Use of alcohol and/or drugs by a family member |
| <input type="checkbox"/> Problems in relationships with the opposite sex | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Problems with siblings | <input type="checkbox"/> Use of tobacco |
| <input type="checkbox"/> Problems with peers | <input type="checkbox"/> Work |
| <input type="checkbox"/> Religious/Spiritual issues | <input type="checkbox"/> Physical Problems |
| <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Physically hurting self |
| <input type="checkbox"/> Obsessions/Compulsions | <input type="checkbox"/> Other Specify _____ |
| <input type="checkbox"/> Perfectionism | |

EDUCATIONAL HISTORY:

Name of school _____ Grade _____

School counselor or principal, if known _____

School phone number: _____ (We will not contact the school without your signed permission)

List previous schools attended with dates:

Has the child ever repeated a grade: Yes No

If so, when and why?

How have teachers or other professionals described your child's problems?

What are the child's grades like now?

Describe any difficulties in learning in school.

Have there been any behavior problems or disciplinary action at school? Yes No

If so, please describe:

Is your child now or ever been in any special education programs? Yes No

If so, please describe:

RELIGIOUS BACKGROUND:

Describe child's religious experience (religious affiliation, denomination, member of a church, attendance in Sunday School and worship services, religious training at home, prayer life, concept of God, etc.)

LEGAL BACKGROUND:

Has your child ever been in any legal trouble? Yes No

If so, please describe:

CUSTODY INFORMATION: Sometimes a child/teen has several adults and/or agencies sharing custody and/or care of the child/teen. If there has been a divorce, adoption or other event to effect custody of the child/teen, please complete the following:

Who has legal custody of the child/teen? (List all involved when custody is being shared)

Give names of biological parents. Describe level of involvement each parent has currently with the child/teen.

Who has physical custody of the child/teen (i.e., who does the child live with)?

Stepparent(s) names (list all)

Adoptive____or Foster____parent(s) Name(s): _____

Address: _____

Phone #: _____

Is the Department of Family & Children Services involved with the child/teen? Yes No

If so, list the name and phone number of social worker: _____

Describe any visitation arrangements/agreement in place?

Describe child/teen adjustment to current home placement:

If child/teen was removed from biological parent(s) home, describe the reason/circumstances under which the child/teen was removed:

Is custody or visitation of the child/teen being disputed? Yes No

If so, please explain:

If someone other than the legal guardian is bringing the child/teen to counseling, a written and notarized consent to treat from the legal guardian is required before counseling can begin. If divorced, written proof of legal custody of child is required.

My signature below serves as my acknowledgement that the above information I've given is accurate and that I accept the risks to client confidentiality by choosing to engage in electronic communication with BreakThru Counseling and Consulting, P.C.

I voluntarily choose and ask that my typed name on the signature line(s) of this document legally represent my electronic signature.

Name of minor Client

DOB of minor Client

Name of Parent/Legal Guardian

Relationship to the child client

Signature of Parent/Legal Guardian

Date