HOPE COUNSELING CENTER

CONFIDENTIAL

CHILD AND ADOLESCENT INTAKE FORM

To be completed by parent or guardian requesting services for a minor child. This information will help your counselor understand your child. It, as all communications with your therapist, will be kept confidential to the full extent of Georgia Law.

BACKGROUND INFORMATION Date_____

Child's Name_____Date of Birth_____Age_____

Child's Address_____

Number *Street* *County*

_____Home Phone:_____

City *State* *Zip Code*

Child lives with: Both biological parents_____ Mother_____ Father_____ Mother & Stepfather_____

Father & Stepmother_____ Other (specify):_____

If parents are divorced, describe custody arrangements:_____

_____

INFORMATION ABOUT CHILD'S MOTHER:

Mother's Name_____Age_____Race_____

Employer_____Occupation_____Hrs/wk_____

Employer's Address_____

Can you be contacted at work by phone? Yes No Work Phone:_____Ext._____

Religious Denomination_____Church_____

Member? Yes No Active? Yes No

Describe any physical problems you have that require medication or physical care:_____

_____

Are you currently receiving medical treatment? Yes No Physician:_____

Medication(s) currently using:_____

Previous Counseling/Therapy? Yes No If yes, when?_____

With whom and for how long?_____

INFORMATION ABOUT CHILD'S FATHER:

Father's Name_____Age_____Race_____

Employer_____Occupation_____Hrs/wk_____

Employer's Address_____

Can you be contacted at work by phone? Yes No Work Phone:_____Ext._____

Religious Denomination_____Church_____

Member? Yes No Active? Yes No

Describe any physical problems you have that require medication or physical care:_____

_____

Are you currently receiving medical treatment? Yes No Physician:_____

Medication(s) currently using:_____

Previous Counseling/Therapy? Yes No If yes, when?_____

With whom and for how long?_____

FAMILY MEMBERS

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 Completed	Occupation

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item. (You may add written comments after areas checked.)

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

1._____ Anger/Temper
2._____ Depression
3._____ Divorce/Separation of Parents
4._____ Adjustment to Parent's Remarriage
5._____ School Performance
6._____ Family Problems
7._____ Fearfulness
8._____ Physical Problems
9._____ Problems with Social Relationships
10._____ Problems Sleeping
11._____ Nightmares
12._____ Sexual Concerns
13._____ Religious/Spiritual Concerns
14._____ Talk of suicide
15._____ Unhappy Most of the Time
16._____ Use of Alcohol
17._____ Use of Other Drugs
18._____ Work
19._____ Worry
20._____ Self-esteem
21._____ Poor Appetite
22._____ Overeating
23._____ Bedwetting
24._____ Soiling
25._____ Cruelty to Animals
26._____ Fire Setting

Other problem(s):_____

_____

Have there been any previous psychological, psychiatric, neurological, or E.E.G. evaluations? Yes No

If yes, please list names, addresses, and dates of contact:_____

_____

Has child had counseling previously? Yes No If yes, please list name(s) of counselor(s), addresses, and dates of contact(s):

_____

_____

Reason for contact:_____

MEDICAL HISTORY

Were there any complications surrounding the child's birth? Yes_____ No_____ If yes, describe:_____

List child's sicknesses, operations, and injuries. Indicate age when occurred, and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:_____

List current medical problems:_____

Is child currently taking any prescription drugs? Yes_____ No_____ If yes, please list:_____

When did your child last have a physical examination?_____

Name of Physician:_____ Address:_____

How is child's vision?_____ Hearing?_____

ACADEMIC/SCHOOL INFORMATION

Name of school_____ Grade_____ Teacher_____

List previous schools attended with dates:_____

Has child ever repeated a grade?_____ If so, which one(s)?_____

How does your child get along at school?_____

Describe difficulties in learning at school_____

Have other family members had learning difficulties?_____

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

Describe your child's religious background (religious denomination, is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.)_____

Anything else you think would be important for the counselor to know:_____

A survey may be mailed to you upon the completion of your counseling experience at the center. Please indicate your preference in the appropriate box below.

You may send the survey ☐ Do not send the survey ☐

SENTENCE COMPLETION
Adolescent Version

NAME _____ AGE _____ DATE _____

1. I would like
2. If I were older
3. Girls
4. My friends think
5. What makes me mad is
6. My father
7. I miss
8. I am scared
9. I often think of myself as
10. My only trouble
11. I dream of
12. Being younger would
13. I hate
14. If I don't get what I want at home
15. What worries me is
16. When I grow up
17. Nothing bothers me more than
18. Other people think I'm
19. I feel unhappy sometimes because
20. Boys

21. There are time when I
22. Being my age is
23. I don’t think I can
24. It’s tough when
25. At home
26. Teachers are
27. If only I were not so
28. If I am left behind
29. Sometimes I think about
30. If I were smarter
31. Sometimes I feel like
32. It is more important to
33. I wonder if I should
34. My mother
35. If my parents had only
36. I would be happier if
37. I’m glad I’m
38. I wish I were
39. If I could choose my family
40. It would be funny if