CHILD/ADOLESCENT INTAKE FORM

Please fill out this form in as much detail as possible. We appreciate your taking time to provide us with this information which will help us understand your concerns and make an accurate diagnosis.

IDENTIFYING INFORMATION

Client's Name (*Last, First*) _____
Age_____ Date of Birth *(mm/dd/yyyy)* _____ Place of Birth (*City, State*)_____
Education _____School _____
Home Street Address_____
City _____State_____ Zip_____
Name of the person completing the form (*Last, First*) _____
Relationship to the client_____

CONTACT INFORMATION

Primary Phone Number_____ Can we leave message: Yes ◉ No ○
Mother's Phone Number_____ Can we leave message: Yes ○ No ○
Father's Phone Number_____ Can we leave message: Yes ○ No ○
Guardian's Phone Number_____ Can we leave message: Yes ○ No ○
Preferred mode for contact: Phone ☐ Text ☐ Voicemail ☐ Email ☐
Emergency contact person's Name_____ Phone_____

FAMILY INFORMATION

Mother's Name (*Last, First*) _____
Age_____ Date of Birth *(mm/dd/yyyy)* _____ Occupation_____
Phone: Primary_____ Work _____ Cell _____
Email Address _____
Age at the time of marriage _____ Age at the time of birth of child _____
Home Street Address_____
City _____State_____ Zip_____

Father's Name (*Last, First*) _____
Age_____ Date of Birth *(mm/dd/yyyy)* _____ Occupation_____
Phone: Primary_____ Work _____ Cell _____
Email Address _____
Age at the time of marriage _____ Age at the time of birth of child _____
Home Street Address_____
City _____State_____ Zip_____

If living away from biological parents, information about foster parents / guardian:

Name	Age	Relationship	Education	Occupation

Siblings:

Name	Age	Relationship	Education	Get along well or not

History of mental health diagnosis in family: Yes ○ No ○
Details_____

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CURRENT MEDICAL AND HEALTH INFORMATION

Current Height _____ Current Weight _____
Pediatrician's Name (*Last, First*) _____
Psychologist's/Psychiatrist's Name (*Last, First*) _____
Any medical conditions: Yes ◯ No ◯
Details_____
Any surgery, serious illnesses or accidents: Yes ◯ No ◯
Details_____
Asthma / respiratory problems: Yes ◯ No ◯
Details_____
History of abuse: Yes ◯ No ◯
Details_____
Allergies: Environmental_____ Food_____ Other_____ None ☐

Last Evaluation	Date	Outcome
Vision		
Hearing		
Ear, Nose, Throat		
Neurologist		
Psychologist		
Medical Specialist		

Does the child wear eyeglasses or contact lenses: Yes ◯ No ◯
Vision problems: _____
Does the child wear hearing aids: Yes ◯ No ◯
History of childhood ear infection: None ◯ Rarely ◯ 1-2 times a year ◯ 3-4 times a year ◯ 5+ times a year ◯
History of ear tubes / ear surgery: Yes ◉ No ◯
Does the child take prescription medication: Yes ◯ No ◯
Date onset _____Reason _____ Outcome_____

PRE NATAL-HISTORY

While pregnant did mother have:

High Blood Pressure:	Yes ◯	No ◯	Excessive Vomiting:	Yes ◯	No ◯
Bleeding / Spotting:	Yes ◯	No ◯	Kidney disease:	Yes ◯	No ◯
Toxemia:	Yes ◯	No ◯	Gestational Diabetes:	Yes ◯	No ◯
Threatened Miscarriage:	Yes ◯	No ◯	German Measles (Rubella):	Yes ◯	No ◯
Illness other than Cold or Flu:	Yes ◯	No ◯	Hospitalization required:	Yes ◯	No ◯
Premature labor:	Yes ◯	No ◯			

History of substance abuse in mother during pregnancy: Yes ◯ No ◯
Details _____
History of medication in mother during pregnancy: Yes ◯ No ◯
Details _____

BIRTH HISTORY

Where was the baby born _____
Was labor induced: Yes ◯ No ◯ Helped by med: Yes ◯ No ◯
Duration of labor _____
Was baby born: early (less than 38 weeks): Yes ◯ No ◯ late: (after 42 weeks): Yes ◯ No ◯
Method of delivery: Spontaneous Vaginal ◯ Forceps / Suction ◯ Breech ◯ Cesarean ◯
Reason _____

During hospital stay did baby have:
Jaundice: Yes ◯ No ◯ Antibiotic: Yes ◯ No ◯ Rash: Yes ◯ No ◯ Blue Spells: Yes ◯ No ◯
Convulsions: Yes ◯ No ◯ Infection: Yes ◯ No ◯ Incubator Care: Yes ◯ No ◯
Remain in hospital longer than normal: Yes ◯ No ◯

DEVELOPMENTAL HISTORY

Approximate age at which the child reached these developmental milestones:

	Age	**If exact age not known; it occurred**		
		Early	**Late**	**Normal**
Hold up head				
Roll over				
Sit unsupported				
Respond to Own Name				
Crawled				
Stand alone				
Walk				
Talk				
Toilet train				
Feed her/himself				
Dress her/himself				
Jump				
Ride a Tricycle				
Read				
Throw & Catch a Ball				
Name Colors				

Please mark any areas which constitute a problem for the child:

Eating: Yes ◯ No ◯ Sleeping: Yes ◯ No ◯
Nightmares: Yes ◯ No ◯ Thumb sucking: Yes ◯ No ◯
Nail biting: Yes ◯ No ◯ Bedwetting: Yes ◯ No ◯
Getting along with friends: Yes ◯ No ◯ Self-help skills (dressing, bathing, etc.): Yes ◯ No ◯
Understanding Directions: Yes ◯ No ◯
Unusual fears: Yes ◯ No ◯

Details: _____

_____

SCHOOL AND EDUCATIONAL INFORMATION

Age started: Daycare _____ Nursery _____Pre-school _____Kindergarten _____

Does the child refuse to go to school: Yes ◯ No ◯ Does the child enjoy school: Yes ◯ No ◯

Is the child in special classes: Yes ◯ No ◯

If yes, please specify_____

Has the child ever repeated a grade: Yes ◯ No ◯

If yes, which grade_____

Is there family history of learning difficulties : Yes ◯ No ◯

If yes, who and what kind/type: _____

Is the child making progress at school: Yes ◯ No ◯

Are you satisfied with the school program for the child: Yes ◯ No ◯

Does the child face trouble in these specific learning areas:

Math: Yes ◯ No ◯ Reading: Yes ◯ No ◯ Writing: Yes ◯ No ◯
Verbal/Oral Expression: Yes ◯ No ◯ Understanding instructions: Yes ◯ No ◯

SOCIAL AND EMOTIONAL INFORMATION

Child's major interest and hobbies_____

_____

Is the child involved in extracurricular activities: Yes ◯ No ◯

If yes, what kind_____

Does the child have Friends: Yes ◯ No ◯

If yes, how many _____ Age range_____

Does the child have difficulty making friends: Yes ◯ No ◯

Does the child have difficulty maintaining friendship: Yes ◯ No ◯

Does the child have behavioral problems at school: Yes ◯ No ◯

Details _____

Does the child have behavioral problems at home: Yes ◯ No ◯

Details _____

Does the child have any of the following psychological symptoms:

Sad / depressed mood ☐	Anger ☐	Panic ☐
General Anxiety ☐	Social Anxiety ☐	School Anxiety ☐
Insomnia ☐	Inattention ☐	Restlessness ☐
Family Stress ☐	Suicidal thoughts ☐	Self-harm ☐
Homicidal thoughts ☐	Bullying ☐	Substance Use ☐
Elopement ☐	Sexuality Concerns ☐	Other ☐

Has the child experienced any traumatic events (e.g., death of a close relative/friend, accident): Yes◯ No◯

If yes, please describe _____

Any other comments that will help us understand the child better: _____

_____

_____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation / treatment by Online Therapy Services for myself and/or my family members.

By signing this consent form, I am providing consent to the use of electronic and verbal signatures to establish my identity and sign electronic documents and forms associated with the provision of care by Online Therapy Services. I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature or verbal approval has the full force and effect of a signature affixed by hand to a paper document.

☐ By checking this box, I accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my care.

Patient/Parent/Guardian Signature (Please type full name)_____

Printed Name: _____

Date:_____