



# PBHS Child & Adolescent Intake Form

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<b>Family Information</b> (Parents, Guardians, Siblings, or Anyone Living in the Home)		
Name and Relationship	Date of Birth	Age (grade if applicable)

<b>Identifying Information</b>		
Primary Address	City	State / Zip Code
Parent/Guardian's Home Phone Number	Parent/Guardian's Cell Phone Number(s)	
Social Security Number	Parent/Guardian's Marital Status	
Secondary Address	Secondary Phone Number(s)	
Are both Parents in agreement to the child receiving agreement? Yes No Please Explain:		
Parent/Guardian Occupations:		
School Child Attends:                      Grade:  Special Education Services Received?		
Church or Religious Affiliation		

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## Presenting Problem

What brought the child here, or made you decide to seek counseling?

Describe any relevant factors in the child's medical health, social skills, and birth/developmental (including family) history

Describe the child's home situation/ family

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Describe ways by which the child deals with stressful events and /or with difficult emotions

What does the child hope to gain from counseling?

## Mental Health Symptoms within the Past 7 days

Symptom	Length of time experiencing that symptom	Are any medications prescribed for the symptom?	Does anything change the way the child feels that symptom?

Comments:

## Alcohol or Drug Use Within the Past Seven Days

Substance	Route	Age 1 <sup>st</sup> use	Frequency	Amount	# days used past month	Date/ amount of last use

Comments:

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Interests / Activities / Hobbies	
What interests, hobbies, or activities does the child enjoy?	Has the child's presenting problems or symptoms disrupted participation in that activity?

**Comments:**

## Risk Assessment over the Past 7 days

Has the child experienced these within the past 7 days?	(Yes or No answer)	If Yes, would the child be willing to contract for safety?
Thoughts of harming / hurting herself / himself		
Described plans to harm / hurt herself / himself		
Thoughts of harming / hurting others		
Intentions / plans of harming someone / others		

**Comments:**

Medication	Dosage	Frequency	Length Taking	Purpose	Side Effects

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## Referral Given

Facility Name and Contact Information	Reason for Referral	Comments
<b>Facility:</b>  <b>Address:</b>  <b>Phone Number:</b>  <b>Fax Number:</b>		

## After Care Plan or Comments:

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

## Child/Adolescent Checklist

\*Educational Placement:      regular              special education

### *Disruptive Behavior*

impulsivity    hyperactivity    short attention span    oppositionality/defiance  
 runaway/truant    cruelty to animals/people    obscene    temper tantrums    stealing  
 lying    fire setting    physical/verbal aggression    destructive behavior  
 other \_\_\_\_\_

### *Anxiety*

difficulty leaving parents/home    school refusal    wetting/soiling self    mutism(won't speak)  
 excessive worries    panic attacks    nausea    other \_\_\_\_\_

### *Developmental*

lack of awareness of others    poor eye contact    social skills    difficulty with  
 Academics    unusual speech, behaviors, gestures    distress over small changes in  
 routine    focusing    ability to concentrate    other \_\_\_\_\_

