Mary Alice
Fuhrer, LCSW

Child/Adolescent Counseling Intake Form

PARENT/GUARDIAN INFORMATION

Name:_____Date:_____

Street Address:_____Phone (h)_____

City, State, Zip:_____Phone (w)_____

E-mail Address:_____ Phone (cell)_____

For Confidentiality, when and where do you prefer to be reached? _____

Marital Status: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed ○ Cohabiting

Occupation:_____

Date of Current Marriage/Separation:_____ Number of Marriages:_____

Who resides in the home:

Name:_____Age:_____ ○ M ○ F

Name:_____Age:_____ ○ M ○ F

Name:_____Age:_____ ○ M ○ F

Name of other Custodial parent:_____ Phone:_____

Occupation:_____

GENERAL INFORMATION (Complete all remaining information according to the child coming for treatment.)

Name:_____Date of Birth:_____ ○ M ○ F

SSN:_____ Age:_____

The child is currently living with:_____

School:_____ Grade:_____

Extracurricular activities/interests:_____

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DEVELOPMENTAL HISTORY

Problems during pregnancy:

[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other_____

Birth:

[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications _____
_____
birth weight ___lbs ___oz.

Infancy:

[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:

[ ] chickenpox (age _____)
[ ] German measles (age ___)
[ ] red measles (age _____)
[ ] rheumatic fever (age ____)
[ ] whooping cough (age ___)
[ ] scarlet fever (age _____)
[ ] autism
[ ] ear infections
[ ] allergies to _____
[ ] significant injuries _____
[ ] chronic, serious health problems _____
[ ] lead poising (age _____)
[ ] mumps (age _____)
[ ] diphtheria (age _____)
[ ] poliomyelitis (age _____)
[ ] pneumonia (age _____)
[ ] tuberculosis (age _____)
[ ] mental retardation
[ ] asthma

Delayed developmental milestones

(only check milestones that did not occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other _____
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Emotional / behavior problems (check all that apply):

[ ] drug use
[ ] alcohol abuse
[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] hyperactive
[ ] animal cruelty
[ ] assaults others
[ ] disobedient
[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behavior
[ ] self-injurious threats
[ ] frequently tearful
[ ] frequently daydreams
[ ] lack of attachment
[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] often sad
[ ] breaks things
[ ] other _____
_____

Social interaction (check all that apply):

[ ] normal social interaction
[ ] isolates self
[ ] very shy
[ ] alienates self
[ ] inappropriate sex play
[ ] dominates others
[ ] associates with acting-out peers
[ ] other _____

Intellectual / academic functioning (check all that apply):

[ ] normal intelligence
[ ] high intelligence
[ ] authority conflicts
[ ] attention problems
[ ] learning problems
[ ] underachieving

Describe any other developmental problems or issues: _____

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MEDICAL INFORMATION

Who is your child's Primary Care Physician?_____ Psychiatrist?_____

How would you rate your child's current physical Health? ○ Excellent ○ Good ○ Fair ○ Poor

Is the child complaining of any physical problems? (headaches, stomach aches...)_____

_____

Previous hospitalization for medical reasons: Date_____ Reason_____

Date_____ Reason_____

Please list any medical conditions or disabilities: _____

Medication(s) Over-the-counter or prescription	**Dosage**

COUNSELING & PSYCHIATRIC HISTORY

Has the child had any previous counseling? ○ Yes ○ No If yes, for how long? _____

For what reason?_____ Name/location of counselor:_____

Has the child ever been diagnosed with or treated for any type of mental illness: ○ Yes ○ No

If yes, which type?_____

Has anyone in the child's family ever been diagnosed/treated for any type of mental illness? ○ Yes ○ No

If yes, which type?_____

Has anyone in the child's family ever been diagnosed/treated for any type of substance abuse? ○ Yes ○ No

If yes, who and when?

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REASONS FOR SEEKING HELP

What concerns about the child have led you to pursue counseling?_____

_____

_____

Where are these concerns causing the most problems? **Check all that apply:**

○ Home ○ Work ○ School ○ Other: _____

When did the present concerns begin to be a problem for the child?_____

What concerns about the child have been identified by others?_____

Please indicate which of the following areas are currently problems for the child. **Check all that apply:**

- ○ Lack of motivation
- ○ Excessive fears or anxieties
- ○ Difficulty being away from specific family members
- ○ Loss of interest in usual activities
- ○ Hearing Voices
- ○ Nightmares
- ○ Difficulty falling asleep/inability to sleep at night
- ○ Decreased/increased appetite
- ○ Hyperactivity
- ○ Temper Tantrums
- ○ Bullying/picking fights
- ○ Refusal to respond to authority
- ○ Getting into trouble at school/play
- ○ Obsessions/compulsion with specific activities
- ○ Crying spells
- ○ Lack of self-confidence
- ○ Difficulty making or keeping friends
- ○ Other: _____

Please indicate any significant life events within the last two years. **Check all that apply:**

- ○ Death of a loved one
- ○ Move/school change
- ○ Legal problems for the family (assault, DUI, etc)
- ○ Birth of a new sibling
- ○ Divorce/Separation
- ○ Medical problems for any family member
- ○ Parental remarriage/new step-siblings
- ○ Trauma (violence, natural disaster, car accident, etc)

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How were you referred? ○ Friend ○ Pastor ○ Physician ○ Other: _____

What do you hope your child will gain from counseling?_____

_____

_____

What do you hope to gain from counseling? _____

_____

_____

CONSENT FOR COUNSELING OF MINORS (age 17 and under)

This is to certify that I give permission for the minor named above to participate in counseling.

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date _____

_____

Emergency Contact Name_____

Relationship to child _____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____