Crossroads
COUNSELING CENTER

CHILD & ADOLESCENT INTAKE

Name: _____
DOB: _____
Chart #: _____
MID/Ins #: _____
MID/Ins #: _____

CLIENT INFORMATION

DATE _____

First Name	Middle Name	Last Name		
Address	City	State	Zip	County
Home Phone	Cell Phone	Work Phone		
Date of Birth / Age	Sex: ☐ Male ☐ Female ☐ Other	Preferred Language:		
Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐More than one race ☐Native Hawaiian ☐Pacific Islander ☐White ☐Decline to report	Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Decline to report			

INSURANCE INFORMATION (Copy of Insurance Card/s Required)

Primary Insurance Name:	**Secondary Insurance Name:**
Subscriber Name / Date of Birth	Subscriber Name / Date of Birth
Subscriber's Address	Subscriber's Address
Subscriber's Telephone #	Subscriber's Telephone #
Client's Relationship to Insured ☐Spouse ☐Partner ☐Child ☐Self	Client's Relationship to Insured ☐Spouse ☐Partner ☐Child ☐Self
Subscriber ID # / Group ID #	Subscriber ID # / Group ID #

Emergency or imminent risk contact:
Name: _____ Telephone# _____ Relationship:_____

How did you hear about us? ___ Yellow Pages ___ Attorney: _____
___ Friend/Client ___ Doctor: _____
___ Internet ___ Other agency: _____
___ Court-ordered ___ Other: _____

Crossroads offers appointment reminders. Check below all the ways you wish to receive a reminder.

☐ To Be Called Telephone Number _____
☐ Text Message Text Number _____
☐ Emailed Email Address _____

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Individuals participating in assessment: _____

Responsible Party Information

Responsible Party Name _____ Relationship to Client _____
Responsible Party Address _____
What is the best way to contact responsible party? _____
Current custody status: ___ Parents ___ Sole Parental Custody ___ Joint Legal Custody
___ DSS Custody ___ Other: _____
List all persons who may be bringing this child to therapy sessions _____
_____

Household Information

Client's current living situation:
___ At home with parents/guardians ___ With other family ___ Foster care
___ Residential placement ___ Other (explain) _____

List all members of the household:

Name	Relationship to Client	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any other significant family members who do not live with client: _____
_____

Social/Family Information

Spiritual preference _____
List any support systems: _____

Normal bedtime: _____ Number of hours usually slept: _____
Where does your child sleep? _____
How is your child usually disciplined? _____
What is your child's diet like? _____
Our household is usually (check all that apply)
___ Quiet ___ Calm ___ Highly structured ___ Lots of conflict
___ Noisy ___ Active/Busy ___ More relaxed/unstructured ___ Tense

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What activities does your child enjoy?

___ Video games ___ Telephone ___ Sports
___ TV/Movies ___ Reading ___ Shopping
___ Internet/computer ___ Art/Crafts ___ Playing outside
___ Being with friends ___ Playing with toys ___ Other _____

Is there anything else you would like for us to know about your child's home life? _____
_____

School Information

School Name _____
Teacher Name(s) _____
Grade Level _____ Academic Performance: ___ Excellent; ___ Good; ___ Fair; ___ Poor; ___ Failing
Behavior in school: ___ Excellent; ___ Good; ___ Fair; ___ Poor; ___ Failing
Special Education Accommodations in place? (e.g. IEP, 504 plans, EC) ___ No ___ Yes
(explain:) _____

Developmental History

Was your child: ___ Planned ___ Breast Fed ___ In Day Care
___ Unplanned ___ Bottle Fed ___ Kept at Home
___ Exposed to medications/drugs/alcohol in the womb
___ Difficult or high-risk pregnancy or delivery

At what age did your child: Talk _____ Walk _____ Potty Train _____
Describe any developmental delays _____
_____

Medical History

Has your child experienced any of the following? (If yes, explain.)

___ Childhood trauma _____
___ Severe illness, injury, surgery _____
___ Allergies (foods, drugs, substances) _____
___ Chronic medical problems _____
___ Significant family medical history _____
___ Significant family mental health history _____
___ Significant family substance history _____
___ Prior mental health diagnosis _____
___ Prior developmental diagnosis _____

Primary care physician _____

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Current medications Name Dosage

_____ _____
_____
_____
_____

Pharmacy Name _____ Telephone # _____
Address _____

Substance Use History

Alcohol _____
Illegal Drugs _____
Prescription Drugs _____
Smoking ☐ Non-Smoker ☐ Current Smoker ☐ Ex-Smoker ☐ Smokeless Tobacco
Other _____

Mental Health Treatment History

List all mental health treatment or hospitalizations:

Facility/Therapist	Purpose	Current	Past
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Response to Treatment: _____

Other agency services/relationships in the last six months:

___ Child Protective Services ___ Justice System ___ Outpatient Mental Health
___ Other DSS Services ___ Disability/Social Security ___ Outpatient Substance Abuse
___ Occupational Therapy ___ Speech therapy ___ Other: _____

Current Treatment Focus

What brings you and your child to our office today? _____
_____
_____
_____

What services are you seeking?

___ Individual Therapy ___ Psychological/Educational Testing
___ Family Therapy ___ Psychiatric Services or Medication Management
___ Other (explain): _____

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I/we would like to address the following: (check all that apply)

___ My child's mood or emotional state
___ My child's school performance
___ My child's cognitive/mental functioning
___ Parenting
___ Divorce
___ Abuse or neglect
___ Grief / Loss
___ My child's behavior
___ My child's sleep, eating, or physical concerns
___ My child's relationships with family or peers
___ Family relationships
___ Cultural adjustment issues
___ Other: _____

Child Assessment: Check all the following that currently apply to your child. Indicate past concerns with the letter "P".

____ Anxiety
____ Depressed mood
____ Panic attacks
____ Racing thoughts or speech
____ Obsessions/Compulsions
____ Excessive fears or phobias
____ Dissociative states
____ Touchy/irritable
____ Nightmares
____ Sleep problems
____ Bedwetting or incontinence
____ Tantrums or "meltdowns"
____ Difficult to parent
____ Conflicting parenting styles
____ Parental marital problems
____ Adopted or in foster care
____ Lots of physical complaints
____ Addictions
____ Parent/child conflict
____ Loss due to death
____ Hurts others
____ Lying
____ Stealing
____ Destroying property
____ Defiance
____ Blames others for mistakes
____ Angry/resentful
____ Lack of conscience
____ Bizarre behavior
____ Clingy
____ Separation anxiety
____ Seems to overreact
____ Parent feels overwhelmed
____ Argues with adults
____ Doesn't seem to listen
____ Seems adultlike or older
____ Life has been unstable
____ Sensitive to noise
____ Social media issues
____ Loss due to other
____ Hyperactive
____ Attention problems
____ Worries all the time
____ Impulsive
____ Low self-esteem
____ Suicidal thoughts
____ Suicide attempts
____ Self-harming
____ Sexually active / acting out
____ Difficulty with change
____ Needs predictability/routine
____ Unexplainable mood shifts
____ Running away
____ Deliberately annoys people
____ Takes excessive risks
____ Seems younger than age
____ Life changes pending
____ Sensitive to feel of clothing
____ Staring off / blacking out

I certify that the information provided above is correct to the best of my knowledge, and that I am authorized to provide such information on behalf of this client.

_____ _____
Signature of Legally Responsible Person Date