Return to:

Toqui Kennedy, MA, LPA

Behavioral Health Intake Form – Child & Adolescent

	Today's Date
Child's Name	Date of Birth
Address	
City State ZIP Code	
Primary Telephone:	☐ home ☐ cell ☐ work
Alternate Telephone:	☐ home ☐ cell ☐ work

We were referred by:

Household Composition

Who lives in the primary residence with the child?

Name	*Age*	*Relationship to Client*	*Name*	*Age*	*Relationship to Client*

Does the child live in a second home? ☐ Yes: How often? ☐ No

Name	*Age*	*Relationship to Client*	*Name*	*Age*	*Relationship to Client*

Parents' Marital Status/Family of Origin

☐ Never Married	☐ Is the child adopted? If so, is child aware?
☐ Married/Civil Union	Siblings names & ages:
☐ Separated, when:	
☐ Divorced, when:	
☐ Widowed, when:	Other significant relationships:
☐ Remarried, when:	

Current Medications

Medication	Dates	Reason	Effectiveness

Child's Medical History		
☐ Asthma	☐ Bowel problems	Allergies:
☐ Recurrent ear infections/tubes	☐ Thyroid disease	
☐ Eye/Vision problems	☐ Diabetes (Type I/Type II)	
☐ EEG, MRI, or CT	☐ German Measles, Whooping Cough, Measles, Mumps, Scarlet Fever, Chicken Pox	Hospitalization:
☐ Headaches/Migraines		
☐ Meningitis/Encephalitis		Surgery:
☐ Seizures	☐ Lead/Toxic chemical exposure	
☐ Head injury/Concussion	☐ Irregular menstrual period	Other:
☐ Developmental delay	☐ Pregnant	
☐ Slow weight gain	☐	

Please check all that that have applied to your child in the past 30 days:		
☐ Can't concentrate/Pay attention	☐ Bedwetting/soiling self	☐ Sees/hears things that are not real
☐ Restless/Hyperactive	☐ Has been bullied	☐ Confused thinking
☐ Talks too much/out of turn	☐ Frequent sadness/irritability	☐ Feels people are "out to get" him/her
☐ Impulsive/Acts without thinking	☐ Tearful/Cries easily	☐ Odd/bizarre thoughts/behavior
☐ Trouble staying seated	☐ Low energy level	☐ Behaves like a younger child
☐ Makes careless mistakes	☐ Loss of interest in favorite activities	☐ Has trouble communicating
☐ Fails to finish things he/she starts	☐ Low self-esteem/Guilt	☐ Sensory experiences/issues
☐ Feeling irritable	☐ Dislike of his/her body	☐ Makes repetitive sounds/movements
☐ Daydreams/Gets lost in thought	☐ Feelings hurt easily	☐ Fascinated with parts of toys
☐ Inattentive/Easily distracted	☐ Has trouble making & keeping friends	☐ Is not affectionate
☐ Has trouble following directions	☐ Severe changes in mood	☐ Lack of imaginary/pretend play
☐ Forgetful/Often loses things	☐ Talks too much/fast/changes topic quickly	☐ Avoids/seems obsessed with certain things
☐ Police contact		
☐ Angry/Resentful	☐ Thoughts racing	☐ Does not seek to share interests
☐ Argues/Does not follow rules	☐ Inflated self-esteem	☐ Does not make friends/is in own world
☐ Annoys others purposely	☐ Difficulty controlling emotions	☐ Does not keep eye contact
☐ Bullies/Threatens/Intimidates	☐ Worries about safety of self/others	☐ Rituals/routines must be followed
☐ Physical aggression	☐ Unusual worries/fears	☐ Needs little sleep (rested after 3-4 hours)
☐ Has set fires	☐ Panic attacks	☐ Cannot fall asleep even though tired
☐ Stealing/Shoplifting	☐ Obsessive thoughts	☐ Problems staying asleep/Nightmares
☐ Temper tantrums/Loses temper easily	☐ Panics when separated from parent	☐ Unable to care for hygiene/nutrition/basic needs
☐ Lies/Blames others for own misbehavior	☐ Unusual behaviors dressing, bathing, mealtime, or counting rituals	☐ Nervous tics or other repetitive, abrupt nervous movements or vocal noises
☐ Cruel to animals	☐ Picky eater	☐ Grief/Loss
☐ Violates curfew/Has run away	☐ Self-injury/Cutting/Burning	☐ LGBTQ concerns
☐ Suspected alcohol/drug use	☐ Suicidal thoughts/threats/actions	☐ Friendship/Relationship problems
☐ School suspensions/Alternative school	☐ Witness to domestic violence	Other:
☐ Inappropriate sexual activity	☐ History of physical abuse	
☐ History of unwanted sexual contact	☐ History of sexual abuse	

Developmental History		
How long was baby in the hospital:	Baby's Weight at Birth:	☐ There were complications at birth. If so, please explain:
Biological Mother's age at birth:		
If child was adopted, child's age at adoption:		
If not biological child of parent, is the child aware of this?		
Any problems experienced by the mother during pregnancy:		

Please describe your child's personality/temperament from age 0 to 3 years:	
☐ Easy going	Other:
☐ Slow to warm up to others	
☐ Demanding and difficult to please	

Did your child reach his or her developmental milestones (i.e. walking, speaking) on time?	☐ **Yes**
If no, please explain:	

Previous Mental Health/Chemical Dependency Treatment		
Therapy/Psychiatrist/Hospitalizations/Testing	Dates	Age

Educational History		
What school does your child attend?		
Current grade:		
Did your child ever repeat a grade? ☐ Yes ☐ No Did your child ever skip a grade? ☐ Yes ■ No		
If so, what grade & reason:		
What kind of grades does your child get:	**Please check any of the following services that your child has ever received or has difficulties with:**	
	☐ Special Ed/Resource Services	☐ IEP
	☐ Occupational Therapy	☐ 504 Plan
Are you satisfied with your child's grades:	☐ Self-contained classroom	☐ Spelling difficulties
	☐ Peer relationship issues	☐ Reading difficulties
	☐ Physical Therapy	☐ Math difficulties
Is your child satisfied with his/her grades:	☐ Speech/Language Therapy	☐ All subject difficulties
	☐ Social work/Counseling at school	☐ Receives after school help
	☐ Has a tutor/in class aide	☐ Gifted/Accelerated classes

Community Linkage
☐ Does your child have a relationship with his/her school counselor/social worker/psychologist? If so, what is their name? :
☐ Is your child involved with the court/legal system? If so, who is the probation officer assigned? :
☐ Has your family had any involvement with child protective services (i.e. DCFS)? If so, is there a caseworker assigned? :

Activity		
Approximately how many hours per day does your child watch TV or play video games?		
Approximately how many hours per day does your child spend completing homework?		
Approximately what time does your child go to bed at night:	Wake up time:	# hours slept:
Please describe special interests/hobbies (i.e. sports, art, reading, church activities, scouts):		
Please describe any job/work history your child has had:		
Please describe your child's strengths (special talents, achievements, abilities):		

Please check any of the following events that have happened in the family in the past 6 months:	**If any relatives have had any of the following conditions, please check the condition and write the person's relationship (i.e. parent, sibling, grandparent) next to it:**	
☐ Change in household conflict	☐ Neurocognitive Disorder/Dementia	☐ Alcohol problem
☐ Separation/Divorce	☐ Speech problems	☐ Drug problem
☐ Marriage	☐ Slow development	☐ Gambling problem
☐ Remarriage	☐ Learning problem (reading/writing/math)	☐ Anger problem/Violence
☐ Death in family	☐ Autism Spectrum Disorder	☐ Hoarding
☐ Loss of job	☐ Intellectual Disability	☐ Self-injury (cutting)
☐ New job	☐ Other Developmental Disability	☐ Abuse perpetrator
☐ Change in living situation	☐ ADHD/ADD	☐ Abuse survivor
☐ Trauma/Injury	☐ Eating Disorder	☐ Seizure disorder
☐ Serious injury/Hospitalization	☐ Depression	☐ Thyroid disease
☐ New baby	☐ Bipolar/Manic Depression	☐ Serious medical problem
☐ Legal trouble	☐ Anxiety	☐ Suicide attempt
☐ Change in military status	☐ Schizophrenia	☐ Completed suicide
☐ Death of a friend/peer	Other:	
Other:		

Is there any other information about your family that you would like us to be aware of?

For provider use:

Document reviewed with patient, _____ Date: _____

(signature)