HOPE COUNSELING CENTER

CONFIDENTIAL

CHILD AND ADOLESCENT INTAKE FORM

To be completed by parent or guardian requesting services for a minor child. This information will help your counselor understand your child. It, as all communications with your therapist, will be kept confidential to the full extent of Georgia Law.

BACKGROUND INFORMATION Date_______________________

Child's Name____Date of Birth_________________________Age______

Child's Address_________________ ____

Number *Street* *County*

____Home Phone:___________________________

City *State* *Zip Code*

Child lives with: Both biological parents_____ Mother_____ Father_____ Mother & Stepfather_____

Father & Stepmother_____ Other (specify):____

If parents are divorced, describe custody arrangements:____

____

INFORMATION ABOUT CHILD'S MOTHER:

Mother's Name____Age________Race______________________

Employer____Occupation____________________________Hrs/wk______

Employer's Address____

Can you be contacted at work by phone? Yes No Work Phone:_________________________Ext.______________

Religious Denomination_____________________________________Church__________________________________

Member? Yes No Active? Yes No

Describe any physical problems you have that require medication or physical care:__________________________________

____

Are you currently receiving medical treatment? Yes No Physician:______________________________________

Medication(s) currently using:____

Previous Counseling/Therapy? Yes No If yes, when?____

With whom and for how long?____

INFORMATION ABOUT CHILD'S FATHER:

Father's Name____Age________Race______________________

Employer____Occupation____________________________Hrs/wk______

Employer's Address____

Can you be contacted at work by phone? Yes No Work Phone:_________________________Ext.______________

Religious Denomination_____________________________________Church__________________________________

Member? Yes No Active? Yes No

Describe any physical problems you have that require medication or physical care:__________________________________

____

Are you currently receiving medical treatment? Yes No Physician:______________________________________

Medication(s) currently using:____

Previous Counseling/Therapy? Yes No If yes, when?____

With whom and for how long?____

FAMILY MEMBERS

List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime:

Name	Relationship To Child	Age	Highest School Grade Completed	Occupation

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item. (You may add written comments after areas checked.)

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Concern					Moderate Concern					Extreme Concern

1.______ Anger/Temper
2.______ Depression
3.______ Divorce/Separation of Parents
4.______ Adjustment to Parent's Remarriage
5.______ School Performance
6.______ Family Problems
7.______ Fearfulness
8.______ Physical Problems
9.______ Problems with Social Relationships
10._____ Problems Sleeping
11._____ Nightmares
12._____ Sexual Concerns
13._____ Religious/Spiritual Concerns
14._____ Talk of suicide
15._____ Unhappy Most of the Time
16._____ Use of Alcohol
17._____ Use of Other Drugs
18._____ Work
19._____ Worry
20._____ Self-esteem
21._____ Poor Appetite
22._____ Overeating
23._____ Bedwetting
24._____ Soiling
25._____ Cruelty to Animals
26._____ Fire Setting

Other problem(s):____

____

Have there been any previous psychological, psychiatric, neurological, or E.E.G. evaluations? Yes No

If yes, please list names, addresses, and dates of contact:_________________________

____

Has child had counseling previously? Yes No If yes, please list name(s) of counselor(s), addresses, and dates of contact(s):

____

____

Reason for contact:____

MEDICAL HISTORY

Were there any complications surrounding the child's birth? Yes_____ No_____ If yes, describe:________________________

____

____

List child's sicknesses, operations, and injuries. Indicate age when occurred, and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:____________________

____

____

____

List current medical problems:____

____

Is child currently taking any prescription drugs? Yes_____ No_____ If yes, please list:______________________

____

When did your child last have a physical examination?______________________________

Name of Physician:________________________Address:________________________

____

How is child's vision?____________________________Hearing?____________________________

ACADEMIC/SCHOOL INFORMATION

Name of school______________________________Grade_________Teacher______________________

List previous schools attended with dates:______________________________________

____

____

Has child ever repeated a grade?__________If so, which one(s)?______________________

How does your child get along at school?____

Describe difficulties in learning at school____

____

Have other family members had learning difficulties?______________________________

____

Describe what your child likes to do for fun, special interests, hobbies, etc.____________________

____

Describe your child's religious background (religious denomination, is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.)______________________

____

____

Anything else you think would be important for the counselor to know:______________________

____

____

A survey may be mailed to you upon the completion of your counseling experience at the center. Please indicate your preference in the appropriate box below.

You may send the survey ☐ Do not send the survey ☐

SENTENCE COMPLETION
Adolescent Version

NAME ____ AGE _____ DATE __________

1. I would like

2. If I were older

3. Girls

4. My friends think

5. What makes me mad is

6. My father

7. I miss

8. I am scared

9. I often think of myself as

10. My only trouble

11. I dream of

12. Being younger would

13. I hate

14. If I don’t get what I want at home

15. What worries me is

16. When I grow up

17. Nothing bothers me more than

18. Other people think I’m

19. I feel unhappy sometimes because

20. Boys

21. There are time when I
22. Being my age is
23. I don’t think I can
24. It’s tough when
25. At home
26. Teachers are
27. If only I were not so
28. If I am left behind
29. Sometimes I think about
30. If I were smarter
31. Sometimes I feel like
32. It is more important to
33. I wonder if I should
34. My mother
35. If my parents had only
36. I would be happier if
37. I’m glad I’m
38. I wish I were
39. If I could choose my family
40. It would be funny if