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**Child/Adolescent Initial Evaluation (Session #1) _____**

Child's full name:_____ Date of birth:_____

Child's Address:_____

City/State/Zip:_____ Phone number:_____

*Optional: Please answer only if comfortable doing so*

Child's Assigned Gender:_____ Gender Identity: _____ Preferred Pronoun: _____

Child's Sexual Orientation: _____

## Presenting Issues

Adult providing intake information: _____

Please state who referred, or suggested, the idea of therapy for your child: _____

_____

Please state what concerns you have about your child at this time and how long you have been concerned. Please explain in detail, noting your child's emotional and behavioral symptoms, as well as their intensity and frequency:_____

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Please explain in detail any high-risk behaviors your child may be currently engaging in, or has engaged in, in the past (e.g., drug/alcohol use, sexual activity, running away, self-harm or suicidal ideation/action, etc.): _____

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Please explain in detail any legal problems your child currently has, or has had, in the past (e.g., involvement with Juvenile Services /court/ probation, etc.) _____

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Please list your child's strengths or areas of success: _____

_____

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If applicable, please list activities outside of school in which your child is actively involved (e.g., sport teams, church, etc.): _____

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Please state if there is a particular parenting style or philosophy you follow. Please state all methods of redirection and discipline you use with your child, how your child responds to discipline, and if these methods have been successful: _____

_____

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_____

Please state what you hope to achieve through counseling: _____

_____

_____

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## Family Dynamics

If known, please list all disorders and conditions that apply within your child's biological family structure, including those of siblings, parents, grandparents, aunts, uncles, cousins, etc. (e.g., depression, anxiety, substance abuse/addiction, genetic disorders, neurological disorders, emotional/physical/sexual abuse, antisocial/criminal behavior, etc.): _____

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Please state if there have been any recent stressors or changes in your environment which may be affecting your child (e.g., divorce or marital problems, death in the family, move to a new home / school / or neighborhood, etc.): _____

_____

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_____

## Parent Demographics

Please complete the information below *as it pertains to your household* noting step-parents or other caretakers present in your home.

<u>Current caretakers:</u>

Parent #1_____

Birthday/age _____

Address _____

Home/work/cell phone numbers _____

Email _____

Occupation / Employer _____

Parent #2_____

Birthday/age _____

Address _____

Home/work/cell phone numbers _____

Email _____

Occupation / Employer _____

If child resides with someone other than biological parents, please explain this arrangement in detail below. If your child is adopted, please provide details of your child's adoption (age at adoption, type of adoption, reasons why adoption was chosen, etc.)

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Please list siblings and/or all other individuals living in your child's home, who these individuals are in relation to your child, and each individual's age:_____

_____

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_____

Please state your child's legal guardian. If parents are divorced or separated, please provide a copy of the most current court order regarding legal and physical custody: _____

_____

_____

Please list an emergency contact for you and your child with full name and telephone numbers:_____

_____

Please note if you have any particular religious, spiritual, or cultural beliefs that you would like incorporated into the counseling process: _____

_____

_____

## Child's Developmental and Medical History

Please list any problems during pregnancy and/or delivery of your child: _____

_____

_____

Please state if your child was exposed to inutero stressors (e.g., mother under emotional stress, mother smoking cigarettes, drinking alcohol or having abused drugs while pregnant, etc.):_____

_____

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Please classify your child's early temperament (e.g., easy, quiet, stubborn, shy, difficult, over active, etc.): _____

_____

Please list any physical, cognitive, or social/emotional delays your child had as an infant / toddler (e.g., weaning, walking, talking): _____

_____

_____

Please list any problems your child has had, or currently has, with sleep, eating, or elimination/ toileting (e.g., constipation, soiling undergarments):_____

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_____

Please list any chronic medical conditions your child currently has, or has had, in the past. If your child is currently in treatment, please state where and with whom: _____

Please detail all of your child's emergency hospital visits, hospitalizations, and surgeries, including child's age, reason, and length of stay: _____

Please list any medications your child *routinely* takes, or has routinely taken in the past, and the reason for this medication: _____

Please list your child's pediatrician with address and telephone number: _____

Please state the last time your child had a physical exam: _____

## Child's School History

Please state your child's current grade, school, and primary teacher: _____

_____

_____

Please explain any identified special needs your child has at school (e.g., emotional, social, learning disabilities) and the care your child is receiving:_____

_____

_____

Please detail your child's school history below:

| Place | **Date** | **Location** | **Any concerns?** | **Reason for Leaving** |
|---|---|---|---|---|
| Daycare | | | | |
| Preschool | | | | |
| Kindergarten | | | | |
| Grade 1 | | | | |
| Grade 2 | | | | |
| Grade 3 | | | | |
| Grade 4 | | | | |
| Grade 5 | | | | |
| Grade 6 | | | | |
| Grade 7 | | | | |
| Grade 8 | | | | |
| Grade 9 | | | | |
| Grade 10 | | | | |
| Grade 11 | | | | |
| Grade 12 | | | | |

## Other Providers for Child, if applicable

Please list *all current providers/agencies* your child is involved with for counseling, developmental, or mental health purposes. Please list the name of provider, telephone number, and what services you and/or your child are receiving:

_____
_____
_____
_____
_____
_____

Please list any *former providers/agencies* who have seen you and/or your child for counseling, developmental, or mental health treatment, including the diagnoses your child received, when these services were received, and from whom received: _____
_____
_____
_____
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_____

Thank you for completing this form.

## *Parent: Please do not complete this page.*

**Child Interview with Therapist**

**Child's view of concerns** ***(age 10 and up)***

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**Child Mental Status Exam**

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**Next Steps**

Clinical impressions:

_____

_____

_____

Preliminary plan for child and family / recommendations:

_____

_____

_____ _____

Greta Zuck, PhD, LCMHCS, NCC, RPT-S Date