HelpNet

Child/Adolescent Intake Information

If you are filling this form out for a minor child, please make sure you fill out all information as it pertains *to the child*.

Name: Date:

Address: City: State: Zip:

Parents names:

Do you have a legal guardian or someone else who helps you make decisions? ☐Yes ☐No

If yes, name: This person is my: ☐Guardian ☐Foster Parent ☐Other

Home Phone: Cell phone:

Birthdate: Age: Gender: ☐Male ☐Female ☐Other

School: Grade:

Emergency Contact: Relationship to minor:

Preferred Telephone: Secondary Telephone:

It is important for you to understand that what you discuss here is confidential. We will not tell your parents or others the information shared with us unless:

1. If child abuse is or has been an issue; or
2. If you express any plan to harm yourself or someone else
3. There is a court order

Under these circumstances, we need to make sure you and all others involved are safe.

Presenting Problem

Briefly state the reason for today's visit:

When did this problem begin?

How have you (or your parents) tried to make things better?

Social/Family History

Who else lives in the home?

Name	Age	Relationship to you

Whom do you rely on for emotional support?

Whom do you get along with best in the home?

Whom do you have the hardest time getting along with in the home?

Are your parents together?

Do you have step-parents or step-siblings? (Please list)

Does anyone in the family use alcohol? Who?

Does anyone in the family use drugs other than alcohol? Who?

What activities do you enjoy?

What community groups or after school activities are you involved in?

Recent Stressful Life Events

Check any of the following that have occurred in the last two years:

☐Difficulties with family members
☐Breakup of important relationship
☐Personal/family illness or injury
☐Difficulties at school
☐Violence
☐Death of a loved one
☐Change in schools
☐Parent left home
☐Changed residences
☐Legal difficulties
☐Other (Please list)

Medical History

Date of last physical: Name of Physician:

Please indicate name and dosage of any medications currently using:

Name of Medication	Dose	What is it for?
Allergies:		

Do you now have or have you ever had any of the following:

☐Diabetes	☐Weight Gain	☐Blackouts	☐Fast Heart Beat
☐Epilepsy	☐Weight Loss	☐Nervousness	☐Blurred Vision
☐Asthma	☐Nosebleeds	☐Crying Spells	☐Sleep Problems
☐Seizures	☐Constipation	☐Stomach Pains	☐Headaches
☐Dizziness	☐Diarrhea	☐Food Cravings	☐Hearing Voices
☐PMS	☐Vomiting	☐No Appetite	☐Head Injury
☐Irregular Cycles	☐Pregnancies	☐Frequent sore throats/colds	☐Chest pains
☐STDs	☐Mumps/Measles	☐Chicken Pox	☐Other

Have you experienced any recent changes in weight?

Have you experienced any recent changes in sleep habits?

Have you ever been diagnosed with a mental health condition (i.e., ADHD, Depression, Bi-polar Disorder)? If so, what, when, and by whom?

CHEMICAL USE PATTERN

	Age of First use	How much	How often	Date of last use
Tobacco				
Alcohol				
Cannabis (Marijuana)				
Sedatives "Downers"				
Crack/Cocaine				
Stimulants "speed" Meth				
Minor Tranquilizers (Xanax)				
Inhalants "huffing" "sniffing"				
Hallucinogens (Acid)				
Opiates (Heroin)				
Ecstasy				
Prescription Drugs				
Weight Loss Pills				
Body Building Pills				
Other				

LEGAL

Have you ever been involved with the law?

Do you currently have a court case pending?

Do you have a probation officer? Who?

Have you spent time in juvenile detention?

EDUCATIONAL/VOCATIONAL HISTORY

Do you feel there are any academic problems?

Are there disciplinary problems in school?

Describe your job history:

FRIENDS/SOCIAL

Who is your best friend?

How would you describe him/her?

Generally, how would you describe your friends as a group?

Who do you confide in when you have a problem?

Have you changed your friendship group over the past two years?

Do you have a boyfriend/girlfriend? How long have you been dating?

What are your strengths?

What activities do you participate in?

SELF HARM/HARM TO OTHERS

Have you ever seriously talked about hurting yourself?	☐Yes	☐No
Have you ever attempted suicide?	☐Yes	☐No
Are you thinking of self harm now?	☐Yes	☐No
Have you ever seriously talked about hurting a person or an animal?	☐Yes	☐No
Have you ever intentionally hurt someone else?	☐Yes	☐No
Are you thinking/talking about hurting someone now?	☐Yes	☐No

If you have had any counseling in the past, please list and describe your experience(s):

Check any feelings you regularly experience:			
☐Suicidal	☐Depressed	☐Hopeless	☐Mad
☐Worthless	☐Powerless	☐ Overwhelmed	☐ Helpless
☐Stupid	☐ Scared	☐ Optimistic	☐ Happy
☐ Sad	☐ Hopeful	☐ Excited	
Other feelings you often feel:			

What is your goal for therapy?

What is your parent's goal for therapy?

Client Signature Date Clinician Signature Date