L2T Intake Form Child/Adolescent

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Parents of minors: please fill out this biographical background form as completely as possible as it will help in our work together. Information is confidential as outlined in the Learn2Thrive Office Policies & Client Agreement for Psychotherapy Services form and the HIPAA Notice of Privacy Practices. Please print or write clearly and bring this form with you to the first session. Your clinician will go through this packet with the client during the intake session as well.

Client Information

Name	
Nickname	
Date of Birth &Age	
Sex & Identified Gender	
Custodial Parent/Legal Guardian	
Race/Ethnicity & Languages Spoken	
Street Address	
City ST ZIP Code	
Phone	
E-Mail Address	
Referral Source	
Emergency Contact & Phone	

Parent Contacts Information

Mother's Name	
Phone & Age	
Occupation	
Home Address	
Father's Name	
Phone & Age	
Occupation	
Home Address	
Parent's Marital Status: S/M/Sep/D If divorced, list visitation agreement	
Other caregivers & relationship to child	

Sibling Name(s)	Age	Nature of Relationship

Foster or Adopted Child

Fostered / Adopted Since & Age	
Open or closed adoption	

If open adoption, how often do they see the birth parents and what is the visitation arrangement? What is the relationship like between the child and birth parents? _____

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Presenting Problem

Please explain the problem you wish to address in therapy. Be as specific as you can and include when it began and how it is currently affecting your child/ adolescent.

How much distress is this problem causing the child/adolescent on scale of 1-10 (10 being most distress)? ___

Problem Checklist – Please check any symptom that has been a concern and include how long it has been a problem

Lack of interest in activities	☐	Excessive worry/fearfulness	☐
Social isolation	☐	Social fears/ shyness	☐
Thoughts of suicide	☐	Separation problems	☐
Suicidal Plans/ attempts	☐	Bedwetting/soiling	☐
Acts of self-harm	☐	Headaches/ stomachaches	☐
Fatigue/ low energy	☐	Odd beliefs/ fantasizing	☐
Unassertiveness	☐	Nightmares/Sleep Disturbance	☐
Mood swings	☐	Frequent tantrums	☐
Depression	☐	Resistive to change	☐
Cries easily	☐	School refusal	☐
Appetite/weight changes	☐	Perfectionism	☐
Low self-esteem	☐	Social Skill Deficits	☐
Forgetful/memory problems	☐	Stealing	☐
Short attention span	☐	Being destructive	☐
Aggressive behavior	☐	Fire setting	☐
Fidgety/ can't keep still	☐	Hurting others/fighting	☐
Not interested in peers	☐	Acts as if no fear	☐
Talks excessively/interrupts	☐	Short tempered	☐
Easily distracted	☐	Easily annoyed/ annoys others	☐
Irritable	☐	Discipline problems	☐
Impulsive	☐	Angry & resentful	☐
Difficult following rules	☐	Lying	☐
Problem completing homework/task	☐	Trouble with the law	☐
Disrespectful to authority figures	☐	Running away	☐
Hurting others sexually	☐	Truancy/Skipping School	☐
Blames others for mistakes	☐	Argumentative/defiant	☐

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Problem Checklist Cont. – Please check any symptom that has been a concern and include how long it has been a problem

Emotionally acts like a younger child	☐	Cries in appropriate situations	☐
Flat or numb emotional expression	☐	Frequent intense emotional outbursts	☐
Lack of coping skills to deal with stress	☐	Frequent conflict with peers	☐
Difficulty making/maintaining friendships	☐	Lack of remorse	☐
Self-injury behaviors (head banding)	☐	High risk behaviors (running into the street)	☐
Unexplained physical complaints	☐	Hoards/gorges food eats strange things	☐
Failure to thrive	☐	Enuresis, encopresis, or constipation	☐
Difficulty reasoning or problem solving	☐	Difficulty with speech	☐
Difficulty planning ahead, anticipating future	☐	Difficulty acquiring new skills	☐
Memory deficits	☐	Difficulty attaching to parental figures	☐
Difficulty self-regulating emotions	☐	Lack of insight with emotions	☐
Intrusive negative thoughts	☐	Problems in dating/relationships	☐
Distrust issues	☐	Problems with boundaries	☐
Flashbacks of past trauma	☐	Issue adjusting to parent's divorce	☐
Fear of being overweight/refusal to eat	☐	Drug/alcohol substance abuse	☐
Unsafe sexual practices	☐	Gender identity concerns	☐
Sexual Orientation Concerns	☐	Religious /Spirituality Concerns	☐
Anxiety/panic attacks	☐	Sleep problems	☐
Picked on/bullied by peers	☐	Lacks empathy	☐

Discipline History

What types of discipline have you found to be most effective in getting your child/adolescent to behave?

What have you found to be the most effective way to get your child/adolescent to listen to you?

Who does most of the correcting with your child/adolescent? (mom, dad, team effort)

Besides the problems already mentioned, has your child/family recently experienced any major changes, positive or negative (moving, new marriage, losses, births, siblings, etc.)?

What words have you used to explain your child/adolescent's current illness to them?

In general, how does your child/adolescent relax, calm down, and deal with stress? (physical activity, music, art, relaxation exercises, bath, prayer, nothing, crying, playing)

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In general, how do you relax or deal with stress?

Are there any cultural, religious, ethnic values or beliefs about health, medication, etc. that we as practitioners should know?

Prenatal/Developmental History – Please answer the following to the best of your knowledge

Pregnancy:

Any prenatal exposure to drugs/alcohol? (cigarettes, marijuana, heroin,)

Any medications taken during pregnancy? (including OTC, anti-depressants, holistic)

Any complications during pregnancy? (preeclampsia, anemia, high environmental toxins exposure, high blood pressure, uterine blood flow issues, low/high weight in mother, STDs in mother, maternal diseases, etc.)

For the mother, any personal stressors going on during the pregnancy? (i.e. going through a divorce, high levels of anxiety or depression, in a domestic violence relationship, losses, major life changes, etc.)

Delivery Information and Any Birth Defects: (Normal, Breech, Full-term, Premature (if so, how many weeks), Transectional, Cesarean, Cleft Palate, Spina Bifida, Congenital heart disease):

Birth Weight: _____ Problems at birth: (i.e. given oxygen, blood transfusion, placed in an incubator, etc.) _____

Method/Issues with feeding: (breastfed, if so for how long, bottle fed, problems latching, colic, etc.)

State approximate age when child did the following:

Walked alone_____ Said first Word_____ Used 2-word phrases _____

Understood and followed simple instructions _____ Toilet trained _____

List any issues with toilet training _____

List any issues with sleep training _____

History pf the Child

In the first two years of life, did your child experience any of the following:

☐ Separation from mother ☐ Separation from father ☐ Multiple caregivers ☐ Neglect

☐ Out of home care ☐ Disruption in bonding ☐ Chronic pain ☐ Chronic Illness

☐ Parental Stress ☐ Witness a traumatic event ☐ Physical/Sexual Abuse

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Education/Occupation

Current Grade: _____ Name of School: _____

Does your child/adolescent receive any special education services? (504 Plan, IEP,)

Has your child/adolescent ever repeated a grade? ☐ Yes or ☐ No If yes, which grade? _____

Describe any academic problems your child/adolescent has experienced in the past or is currently experiencing:

Describe any social issues your child/adolescent has experienced in the past or is currently experiencing:

Additional Info for Teens:

Do you work a part time job?☐ Yes or ☐ No If yes, where? _____

Do you currently have your driver's license ☐ Yes or ☐ No?

What time is your curfew on weeknights? _____ weekends? _____

Do you have a school counselor? ☐ Yes or ☐ No If yes, what is their name? _____

Do you find school to be stressful? ☐ Never ☐ Occasional ☐ Several Days ☐ Nearly Every Day

Mental Health Treatment History

Provide past and present mental health treatment (i.e. hospitalizations, psychotherapy, pastoral counseling, group therapy). Please provide information such as dates of treatment, treatment setting (outpatient, inpatient, residential), and reason for treatment. Please include a brief description of your relationship with treatment providers, your child/adolescent's relationship with the provider, and how helpful it was for each of you, and how/why it ended.

List past and current psychotropic medications taken, prescribing physician, their effectiveness, and why they were discontinued:

Past suicide attempts or violent behavior (describe: ages, reasons, circumstances, how, etc.):

Substance Use/Treatment History – For the adolescent/teen to fill out:

Do you drink socially? ☐ Yes or ☐ No If yes, how many drinks do you have per week? _____

Do you think that you may have a problem with alcohol or drugs? ☐ Yes ☐ No ☐ Unsure

If yes or unsure, please explain: _____

Do you currently attend AA, NA, or another addiction support group? ☐ Yes or ☐ No

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Have you ever received treatment for drug/alcohol/gambling/other abuse or addiction? ☐ Yes or ☐ No
If yes, please provide past treatment dates, provider name, and type of treatment (outpatient, inpatient, or residential):

Does someone in your family have an addiction or abuse alcohol or drugs? ☐ Yes or ☐ No If yes, please explain the nature of the addiction and its impact on you:

Does the peer pressure or temptation of drugs/alcohol seem to be a problem for you? ☐ Yes or ☐ No
Do you smoke cigarettes or vape? ☐ Yes or ☐ No

Medical History

Past & present medical care (only list major medical problems, surgeries, accidents, falls, illness, etc.):

Specify medication(s) you are presently taking and for what. Please print clearly:

Pertinent Family Medical History (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc.):

Legal History

Are you involved in any current or pending civil or criminal litigations, lawsuits, divorce proceedings or custody disputes? ☐ Yes or ☐ No (If yes, please explain):

Has the client ever been in jail? ☐ Yes or ☐ No (If yes, provide dates and the nature of the event):

Additional Family History

Please provide any significant family history of mental illness, alcoholism, substance abuse, violence, or legal involvement (including suicide, depression, anxiety, ADHD, OCD, psychiatric hospitalizations, abuse, treatment for addiction, etc.).
Maternal side of the family:

Paternal side of the family:

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Cultural History

Please describe the client's cultural and ethnic upbringing:

Have they ever experienced discrimination? ☐ Yes or ☐ No (If yes, please explain)

Spiritual History

Please describe the client's church background (how they were raised):

How important is spirituality/faith to your family? To the client?

Do you want to integrate spiritual matters or faith into the therapy sessions? ☐ Yes ☐ No ☐ Unsure

Social Support & Engagement

Who are the most supportive people in the client's life?

Please describe the client's friendships and how much time they spend with friends:

Do you feel that their current technology use is balanced and healthy? ☐ Yes ☐ No ☐ Unsure
If not, please explain:

Estimate how many hours per day they spend online on the following:
Social Media: _____ YouTube: _____ Gaming: _____ Texting: _____ Browsing: _____ Other: _____

Hobbies/ Interest

Please describe the client's hobbies/interests:

Does the client or your family participate in any community involvement or organizations? ☐ Yes or ☐ No
Please describe:

Does the client exercise? ☐ Yes or ☐ No If yes, how many times per week and what type of exercise do they do?

Client Signature Page

Office Policies & Client Agreement for Psychotherapy Services

I have read the Learn2Thrive Office Policies & Client Agreement for Psychotherapy Services carefully (a total of 5 pages including this signature page); I understand them, I agree to comply with them, and give my consent to receive therapy at Learn2Thrive. My signature confirming this is below:

Client name (print): _____

Signature: _____ Date: _____

Client name (print): _____

Signature: _____ Date: _____

Therapist's Name (print): _____, ***Authorized agent of Learn2Thrive LLC***

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practice

I have received a copy of Learn2Thrive LLC's Notice of Privacy Practices. My signature confirming this is below:

Client name (print): _____

Signature: _____ Date: _____

Client name (print): _____

Signature: _____ Date: _____

It is your right to refuse to sign this document, however treatment will not be provided without your consent to the Office Policies and Client Agreement for Psychotherapy Services and a notation will be made below that an effort was made to obtain your signature to the Acknowledgement of Receipt of the Notice of Privacy Practices form.

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Client Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that all representatives from Learn2Thrive communicate financial, mental health, medical, and client information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following indicating how you would like to be contacted.

Name: _____ Client #: _____

Please contact me in the following manner (check all that apply):

Phone Communications

☐ OK to contact me at this phone number (Circle H / W / M): _____

☐ OK to text appointment information on cell number listed above

☐ OK to leave message with your name and call-back # on voicemail or answering machine

☐ OK to give appointment information to following individual(s): _____

Written Communication

☐ Do not mail any written client information to me

☐ OK to mail any written client information to this address on file

☐ OK to mail my client information to other address: _____

☐ OK to FAX to the following number: _____

☐ You can communicate by E-mail with me at: _____

I understand that there are risks to confidentiality involved in using e-mail and texting and if I check the boxes allowing either form of communication, I agree to accept such risks. I am aware that any email or text exchanges are a part of my client file.

Representatives from Learn2Thrive LLC will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form. By your signature below, you agree to be communicated in the above manner.

Client Signature: _____ Date: _____