Willow Creek Clinic
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CHILD/ADOLESCENT CLIENT INTAKE FORM

CHILD/ADOLESCENT'S NAME: ____

TODAY'S DATE:____________________________

CHILD/ADOLESCENT'S GENDER (circle): Male/Female/Other: ____________ RACE/ETHNICITY: ________________________________

BIRTH DATE: ________________________________ AGE: _______________ GRADE: __________________

CHILD/ADOLESCENT'S SCHOOL ____

SPECIAL EDUCATION SERVICES, IF ANY: ____

PERSON FILLING OUT THIS FORM (circle): Mother/Father/Stepmother/Stepfather/Grandparent/ Other: _______________________

NAME(S) OF LEGAL GUARDIAN(S): ____

RELATIONSHIP TO CHILD/ADOLESCENT: ____

PARENTS' MARITAL STATUS: ____

DESCRIBE CUSTODY ARRANGEMENT, IF APPLICABLE: ____
____

WHO REFERRED YOU HERE? ____ PHONE: ________________________________

REFERRAL ADDRESS: ____ EMAIL: ___________________________________

REASON FOR VISIT

Please describe the reason for your current visit, including any difficulties that your child is having:
____
____
____
____

How long have these difficulties been of concern? ________________; When was this problem first noticed? ____________________

Has your child received evaluation or treatment for the current concern or similar concerns? Yes ________; No _________

If yes, please describe previous treatment: ____
____
____

Is there any legal action currently underway in the family? Yes ______ No ______ If yes, please explain: ____________________
____
____

Describe any major life event that might be related to your concern (e.g. death in family, trauma, move, family conflict, natural disaster): ____
____
____

Has your child ever had previous counseling or psychotherapy? Yes ___; No ___
If Yes, by whom and when? ____
Reason for treatment? ____

If currently receiving counseling or psychotherapy elsewhere, describe reason for seeking services here: __________________
____
_

Has your adolescent ever been psychiatrically hospitalized? Yes ___ No ___; if Yes, when and where?
____
____
____

Has your child ever made a suicide attempt/gesture? Yes ___ No ___; if yes, when (please explain):
____
____
____

Please use the scale below to indicate your adolescent's current level of distress with the following items:

	No Concern	Some	Moderate	Urgent
Academic problems………………………………………	0	1	2	3
Aggressive behavior …………………………………….	0	1	2	3
Anxiety/fears/worries………………………………….....	0	1	2	3
Attention/concentration difficulties……………………..	0	1	2	3
Bedwetting ………………………………………………	0	1	2	3
Behavior problems ……………………………………....	0	1	2	3
Change in family constellation (e.g. divorce/remarriage)..	0	1	2	3
Depression ………………………………………………	0	1	2	3
Eating problems …………………………………………	0	1	2	3
Feelings over a recent loss/death ………………………..	0	1	2	3
Losing contact with reality ………………………………	0	1	2	3
Relationship with family …………………………………	0	1	2	3
Relationship with peers …………………………………..	0	1	2	3
Problems with alcohol/drugs ……………………………..	0	1	2	3
Sexual behaviors …………………………………………	0	1	2	3
Sleep problems …………………………………………..	0	1	2	3
Suicidal feelings/behaviors ………………………………	0	1	2	3
Trauma/physical or sexual abuse ………………………...	0	1	2	3

DEVELOPMENTAL HISTORY

Was your child adopted? Yes ______; No ______; if yes, child's age at adoption: ____________

PREGNANCY: Duration of pregnancy (weeks or months): _________________________

During the pregnancy, did the mother experience any of the following complications (please check all that apply): _____ Suffer from illness or disease; _____ Excessive staining or blood loss; _____ Suffer from an accident; _____ Threatened miscarriage; _____ Undergo surgery; _____ Infection; _____ Take medication; _____ Toxemia; _____ Undergo x-ray studies; _____ Diabetes; _____ Smoke tobacco; _____ High blood pressure; _____ Consume alcohol; _____ Poor nutrition; _____ Use illegal drugs; _____ Other (specify): ____

DELIVERY:

Duration of Labor: _________________ hours; Birth Weight: _______ lbs. _______ ozs.; Apgar Score: _____________________

Type of Labor (circle): Spontaneous _____; Induced _____ Type of Delivery; (please circle): Vaginal _____; Caesarean _____

Delivery Complications:

_____ None; _____ Delay in breathing; _____ Cord around neck; _____ Injury to infant; _____ Hemorrhage; _____ Fetal distress;

_____ Placenta problems; _____ Meconium aspiration; _____ Other (specify): ____

NEWBORN AND POST-DELIVERY PERIOD:

Total days baby was in hospital after delivery: __________; Was your baby in the NICU? Yes _____; No ______

Birth complications (check all that apply):

___ None; ___ Jaundice; ___ Respirator required; ___ Addiction; ___ Infection; ___ Resuscitation required; ___ Anemia;

___ Seizures; ___ Birth defects (specify): _________________________; ___ Trouble breathing; ___ Cyanosis (turned blue);

___ Intraventricular hemorrhage; ___ Other (specify): ____

INFANCY-TODDLER PERIOD:

Briefly describe your child/adolescent's temperament during infancy:
____

Were any of the following present during the first few years of life (check all that apply)?

___ Colic; ___ Constantly into everything; ___ Reflux; ___ Slow or unable to adapt to changes in routine; ___ Feeding problems;

___ Excessively high or low activity level (circle one); ___ Sleeping problems; ___ Was not calmed by being held and/or stroked;

___ Frequent head banging; ___ Excessive number of accidents compared to other children; ___ Excessive restlessness;

___ Withdrawal or other problems adjusting to new people and situations; ___ Did not enjoy cuddling; ___ Variable or irregular body functions (sleep, hunger, bowel, etc.)

Were there any special problems in the growth and development of your child/adolescent during the first year? Yes ______ No ______

If Yes, please describe:
____
____
____

Looking back, did you ever think that your child/adolescent was different from other children/adolescents in some significant or concerning way?

Yes ____ No ____; if so, when? _________; What did you notice that was different? ____
____
____
____
____
____
____
____
____
____
____
____
____

DEVELOPMENTAL MILESTONES:

The following is a list of infant developmental milestones. Please indicate the age at which you're child/adolescent first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Crawled	_______	Became toilet trained	_______
Walked alone	_______	Stayed dry at night	_______
Spoke first single words	_______	Fed self	_______
Put words together	_______	Rode tricycle	_______

Compared to other children, your child's early development was: ______ Normal; ______ Delayed; ______ Advanced

HOME INFORMATION

Mother's name: ________________________; Age: ___ Education: ____________; Occupation: ____________________________

Father's name: _________________________; Age: ___ Education: ____________; Occupation: ____________________________

Stepmother's name: _____________________; Age: ___ Education: ____________; Occupation: ____________________________

Stepfather's name: ______________________; Age: ___ Education: ____________; Occupation: ____________________________

If parents are separated or divorced, how old was the child when the separation occurred? __________________________________

List siblings and others living in the home:

NAME	RELATIONSHIP TO ADOLESCENT	AGE

List any siblings living outside of the home:

NAME	RELATIONSHIP TO ADOLESCENT	AGE

Primary language spoken at home: _________________________; Any other languages spoken at home? ______________________

What your total annual household income (from all sources) before taxes (specify sources)? __________________________________

Provide any other important information about home: ____

____

____

FAMILY MEDICAL HISTORY

Place a check next to any illness, condition, or problem experienced by any blood relative. When you check an item, please note the relative's relationship to the adolescent. If any problems run in the family, please specify at the end of the list.

	CONDITION	RELATIONSHIP TO ADOLESCNET	
_____	Alcoholism...	____________________	(specify): _____________________
_____	Antisocial (criminal) behavior...	____________________	(specify): _____________________
_____	Autism Spectrum Disorder	____________________	(specify): _____________________
_____	Asperger's Disorder...	____________________	(specify): _____________________
_____	Bipolar (Manic-depressive) Disorder	____________________	(specify): _____________________
_____	Depression	____________________	(specify): _____________________
_____	Drug addiction or drug problems..	____________________	(specify): _____________________
_____	Headaches (e.g. migraine)	____________________	(specify): _____________________
_____	ADHD (Hyperactivity / Attention problems).......................	____________________	(specify): _____________________
_____	Language disorder or delay	____________________	(specify): _____________________
_____	Learning problems...	____________________	(specify): _____________________
_____	Developmental Delay / Mental Retardation	____________________	(specify): _____________________
_____	Tic or Movement Disorders...	____________________	(specify): _____________________
_____	Nervous or mental problems..	____________________	(specify): _____________________
_____	Schizophrenia	____________________	(specify): _____________________
_____	Seizures, Epilepsy, or convulsions	____________________	(specify): _____________________
_____	Sexual / physical abuse..	____________________	(specify): _____________________
_____	Suicide or suicide attempt	____________________	(specify): _____________________
_____	Other (specify)	____________________	(specify): _____________________

ADOLESCENT'S MEDICAL HISTORY

Pediatrician's name: ___________________________ Address: ____
Phone: __________________________ Fax: _________________________; Email: ____

Has your child/adolescent ever been treated with medication other than for colds and minor infections? _______ Yes; _______ No
If Yes, please complete medication information below. Place a check under "Current?" for those medications the adolescent is currently taking.

If yes, list medication(s), current dosage(s), reason prescribed?, and prescribing doctor(s):

Medication and Dosage	When & Reason it was Prescribed?	Prescribing Doctor	Current?

Do you get all of your child's prescription medicines filled at the same pharmacy? _______ Yes; _______ No
If No, describe reason and list pharmacies (including online sites) where you get your adolescent's medications:
____
____

Has your child ever had any adverse or negative side effects related to any medication(s) taken? _______ Yes; _______ No
If Yes, list medication(s) and describe side effects: ____
____
____

Is your child allergic to any medication(s)? _______ Yes; _______ No
If Yes, describe: ____
____

Is your child/adolescent currently taking any supplements, vitamins, or herbal remedies? _______ Yes; _______ No
If Yes, list name(s), current dosage(s), how long, and reason for taking:

Names and Dosages	How Long Taken	Reason(s) for Taking?
___________________________________	____________________	____
___________________________________	____________________	____
___________________________________	____________________	____

Is your child/adolescent allergic to any supplement(s)? ____ Yes ____ No; if yes, describe:
____
____

Has your child/adolescent ever suffered from a head injury that caused confusion or loss of consciousness? _______Yes; _______ No

Place a check next to any illness or condition that your child/adolescent has had. When you check an item, also note your child's approximate age at the time of the illness.

Illness or condition	Age or Dates	Illness or condition	Age or Dates
____ AIDS or HIV+	___________	____ Cystic Fibrosis	___________
____ Allergies	___________	____ Dazed/Unconscious	___________
____ Anemia	___________	____ Dementia	___________
____ Aneurysm	___________	____ Diabetes	___________
____ Anoxia	___________	____ Dysarthria	___________
____ Arteriovenous Malformation	___________	____ Dyspraxia/Apraxia	___________
____ Arthritis	___________	____ Ear Infection (PE Tubes)	___________
____ Asthma	___________	____ Other Ear Problems	___________
____ Ataxia	___________	____ Eczema/Hives	___________
____ Auto Accident	___________	____ Encephalitis	___________
____ Back Pains or Problems	___________	____ Epilepsy/Seizures	___________
____ Bleeding Problems	___________	____ Fainting Spells	___________
____ Blood Disorders	___________	____ Fetal Alcohol Syndrome	___________
____ Bone or Joint Disease	___________	____ Fever (if very high or prolonged)	___________
____ Broken Bones	___________	____ Guillain-Barre	___________
____ Cancer	___________	____ Head Injury	___________
____ Chorea	___________	____ Headaches	___________
____ Coma	___________	____ Heart Disease	___________
____ Lead Poisoning	___________	____ Scarlet Fever	___________
____ Hepatitis	___________	____ Sensory Losses	___________
____ Herpes	___________	____ Sexual Molestation	___________
____ High Blood Pressure	___________	____ Sexually Transmitted Disease	___________
____ Jaundice	___________	____ Speech/Language Problems	___________
____ Leukemia	___________	____ Spells (______________________)	___________
____ Malnutrition	___________	____ Stroke	___________
____ Meningitis	___________	____ Sunstroke/Heat Exhaustion	___________
____ Muscular Disease	___________	____ Thyroid Problems	___________
____ Pain Problems	___________	____ Trauma (_____________________)	___________
____ Paralyisis	___________	____ Tuberculosis	___________
____ Pituitary Disorder	___________	____ Tumor	___________
____ Pneumonia	___________	____ Visual Problems	___________
____ Poisoning	___________	____ Whooping Cough/Pertussis	___________
____ Poliomyelitis	___________	____ Other Medical Problem(s) ________________________________	
____ Rheumatic Fever	___________	____	
____ Chronic Fatigue	___________	____	

Indicate if your child/adolescent has undergone any of the following medical tests (please check and give age):

____ Electroencephalogram (EEG)	___________	____ Skull X-Ray	___________
____ CT/CAT Scan	___________	____ Ophthalmological (Vision)	___________
____ MRI Scan	___________	____ Audiological (Hearing) Evaluation	___________

EDUCATIONAL HISTORY

SCHOOL: ________________________________ CURRENT GRADE: _____________ Grades repeated (if any): ___________

SCHOOL PHONE: ____________________________ PRINCIPAL: ____

LEAD TEACHER: ____

SPECIAL EDUCATION CLASSIFICATION (if any): ____

Describe any academic or behavioral concerns at school: ____

____

____

____

Previous school placements / Experiences: ____

____

____

____

List or estimate current report card grades: ____

____

Describe special services or modifications: ____

____

____

Describe private services (speech / language, occupational therapy): ___________________________________

____

____

HOME BEHAVIOR

What discipline techniques are effective in your home? ____

____

____

What discipline techniques are usually not effective? ____

____

____

What are your child/adolescent's favorite activities (e.g., hobbies, sports, recreational, TV etc.) and/or toy preferences?

____

____

____

____

____

What are your adolescent's assets or strengths (e.g., special skills or talents)?

____

____

____

____

____

Is there any other information that might help me to understand your child/adolescent?