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## Confidential Information – Child /Adolescent Intake

(Please Print and use black ink)

Name of Child \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Date of Assessment \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age: years \_\_\_\_\_ months \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name of Parent \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Parent's Email Address \_\_\_\_\_

### Current Family Situation:

**Mother's Relationship to child:** \_\_\_ Natural parent \_\_\_ Step-parent \_\_\_ Adoptive parent \_\_\_ Relative

Age \_\_\_\_\_ Education \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Father's Relationship to child:** \_\_\_ Natural parent \_\_\_ Step-parent \_\_\_ Adoptive parent \_\_\_ Relative

Age \_\_\_\_\_ Education \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Marital History of Parents: Natural Parents:** \_\_\_ married / when \_\_\_\_\_  
\_\_\_ separated/ when \_\_\_\_\_  
\_\_\_ divorced/ when \_\_\_\_\_  
\_\_\_ deceased/ M/F \_\_\_\_\_

**Step-Parents:** \_\_\_ married / when \_\_\_\_\_  
\_\_\_ separated/when \_\_\_\_\_  
\_\_\_ divorced/ when \_\_\_\_\_  
\_\_\_ deceased/ M/F \_\_\_\_\_

### If Child is Adopted:

Adoption Source \_\_\_\_\_ Age of child at adoption \_\_\_\_\_ Date of adoption \_\_\_\_\_

Reason and circumstances \_\_\_\_\_

What has the child been told about his/her adoption? \_\_\_\_\_

### Living Arrangements:

**Other Family Members:** Place a check mark beside the name(s) of those with whom the child now lives. Circle (M)ale or (F)emale

Siblings _____	Age _____	M/F _____	Parents _____	M/F _____	Grandparents _____	M/F _____
_____	Age _____	M/F _____	_____	M/F _____	_____	M/F _____
_____	Age _____	M/F _____	_____	M/F _____	_____	M/F _____
_____	Age _____	M/F _____	_____	M/F _____	_____	M/F _____
_____	Age _____	M/F _____	_____	M/F _____	_____	M/F _____
_____	Age _____	M/F _____	Others living in the home and relationship _____			M/F _____

### Medical Information:

**Normal Pregnancy with child:** YES \_\_\_ NO \_\_\_ If no, please explain: \_\_\_\_\_

**Full Term:** YES \_\_\_ NO \_\_\_ If no, please explain: \_\_\_\_\_

**Birth weight:** \_\_\_ lbs. \_\_\_ oz. **Type of delivery:** \_\_\_\_\_ **Any complications?** \_\_\_\_\_

Family Physician / Pediatrician / Psychiatrist / Etc. (Doctor(s) seen routinely):

[1] Name \_\_\_\_\_ Phone \_\_\_\_\_ Years seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

[2] Name \_\_\_\_\_ Phone \_\_\_\_\_ Years seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Does the child have any current or ongoing medical problems, symptoms, hospitalizations? Please explain: \_\_\_\_\_

Current Medications:

Taken as prescribed?

Medication	Dosage	Yes	No	Doctor	Reason	How Long?
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			

Previous Mental Health Services:

Type of Services	Provider	Date of Services

Other Information:

Current or expected legal involvement?  Yes  No Current Order of Protection or Restraining Order?  Yes  No

If yes, please explain: \_\_\_\_\_

Referred by: \_\_\_\_\_ Friend / Doctor / Therapist / Agency / Church Phone: \_\_\_\_\_

May I have your permission to thank this person for their referral?  Yes  No Initials: \_\_\_\_\_

Person(s) to notify in case of any emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Please provide your signature to indicate that I may contact them, if needed. (Your Signature): \_\_\_\_\_

Religious affiliation: \_\_\_\_\_ Frequency of involvement/activities \_\_\_\_\_

Child's current level of satisfaction with friends and social support: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent) Circle level

What do you consider to be your child's strengths? \_\_\_\_\_

Briefly describe the problems and reasons that brought you here: \_\_\_\_\_

What would you like to achieve and/or see happen by coming here for care? \_\_\_\_\_