DESERT STREAMS Christian Counseling
Quality Counseling Integrated with Faith

CHILD/ADOLESCENT
INTAKE ASSESSMENT **Date** _____

Child's name _____ **M F** **Social Security #** _____
Address _____ **DOB** _____
City _____ **State** _____ **Zip Code** _____ **Phone** _____
Parent(s)/Guardian(s) _____
Email Address _____ **Alternate Phone** _____
Emergency Contact _____ **Relationship** _____ **Phone** _____
Who lives in the home at the current time? (name, age, relationship) _____
_____
_____
_____

Reason for seeking counseling _____
_____
_____
_____

Has the child had previous counseling? ☐ Yes ☐ No ☐ Only as part of family
Where? _____ When _____
Was it helpful? _____
_____
_____

Has the child had previous substance abuse treatment? ☐ Yes ☐ No ☐ Only as part of family
Where _____ When _____
Was it helpful? _____
_____
_____

EDUCATIONAL HISTORY

School _____ **Grade** _____ **Teacher** _____
School Counselor/Social Worker _____
Has the child ever been diagnosed? ☐ Learning disability ☐ ADHD ☐ Sensory Integrative
☐ Autism ☐ Oppositional Defiant ☐ Emotionally Impaired ☐ Physical Impairment
☐ Pervasive Developmental Dis.
Describe the child's academic performance: _____
_____
Does the child struggle with distractibility? ☐ Yes ☐ No ☐ School thinks so, I'm not sure
☐ Sometimes
Has the child struggled with any of the following? ☐ Truancy ☐ Suspension ☐ Fighting
☐ Vandalism ☐ Expulsion ☐ Defiance ☐ School refusal ☐ Threatening behaviors
☐ Weapons ☐ Separated from parent
What does the child do well at school? _____
Has the child ever been held back? ☐ No ☐Yes, when? _____

LEGAL SYSTEM INVOLVEMENT

Has the child been involved with the legal system? ☐ Yes, in the past ☐ Currently ☐ No
If so, please explain _____
_____

Is the child on probation? ☐ No ☐ Yes, probation officer _____

FAMILY HISTORY

Does anyone in the extended family unit have a history of alcoholism? ☐ No ☐ Yes, please explain
_____

Drug abuse? ☐ No ☐ Yes, please explain _____
Depression? ☐ No ☐ Yes, please explain _____
Anxiety? ☐ No ☐ Yes, please explain _____
Mental Illness? ☐ No ☐ Yes, please explain _____
Other Addictions? ☐ No ☐ Yes, please explain _____
Has the child ever been abused? ☐ No ☐ Yes, ☐ Physical ☐ Emotional ☐ Sexual ☐ Spiritual
☐ Verbal explain _____

HEALTH HISTORY

Where was the child born? _____
Adopted? ☐ No ☐ Yes, at age _____
Explain any complications the mother had during pregnancy or labor _____
_____

Child's physician/pediatrician _____
_____

Is the child being treated for a medical condition? _____
_____
_____

Please list hospitalizations _____
_____
_____

Please list current medications _____
_____
_____
_____

Please list current allergies _____
_____

Has the child ever had a seizure? ☐ No ☐ Yes, specify _____
Has the child ever had a head injury? ☐ No ☐ Yes, specify _____
Does the child complain of frequent headaches? ☐ No ☐ Yes, specify _____
Does the child complain of dizziness? ☐ No ☐ Yes, specify _____
Does the child have current difficulties with wetting/soiling? ☐ No ☐ Yes, specify _____
_____

Does the child have adequate personal hygiene habits? ☐ No ☐ Yes
At what age did the child walk _____ talk _____ complete toilet training _____

Eating Habits? ☐ No Change ☐ Not Eating ☐ Over-Eating ☐ Significant Weight Change ____lbs.
☐ Selective Eating Habits _____
☐ Other _____
Sleeping Habits? ☐ No Change ☐ Trouble Getting To Sleep ☐ Trouble Staying Asleep
☐ Early Waking ☐ Sleepwalking ☐ Nightmares/terrors ☐ Other _____

HARMFUL BEHAVIORS

Are you concerned about suicidal statements or gestures with the child? ☐ No ☐ Yes, explain _____ ☐ Prior Attempt, explain _____

Are you concerned about the child seriously injuring others? ☐ No ☐ Yes, explain _____ _____ ☐ Prior Attempt, explain _____

Other risk/safety factors _____
_____

PERSONALITY

Does the child form friendships easily? ☐ Yes ☐ No ☐ Only in small crowds
Does the child struggle with any of the following? ☐ "Late Bloomer" ☐ Bullying ☐ Easy Target ☐ Extremely Shy ☐ Needs Social Reassurance ☐ Other _____
Who is the child's best friend at the current time? _____
What does the child do well socially? _____
_____
_____
What are some of the child's favorite activities/toys? _____
_____
_____
_____
Is the child a part of any groups/organizations? ☐ No ☐ Yes
If yes, what? _____
Cultural Heritage _____

SPIRITUALITY

Is your family affiliated with a church? ☐ No ☐ Yes, where? _____
Who is the minister/reverend? _____
How often do you attend? ☐ Regularly ☐ Sporadically ☐ Holidays ☐ Never
Is the child involved in a church youth group? ☐ No ☐ Yes ☐ Sometimes

PREPARATION FOR COUNSELING

Have you spoken with the child about why he/she is coming to counseling? ☐ No ☐ Yes
What is the last major change in the child's life? _____
_____
Has the child ever experienced a traumatic event? ☐ No ☐ Yes, explain _____
_____
_____
Is there anything else that the therapist should know about the child? _____
_____
_____
_____
Is there anyone else who should be invited into the counseling process with the child? ☐ No ☐Yes, Whom _____
Comments _____
_____
_____

TREATMENT PLANNING

What would you like to see occur from counseling services for the child? _____
_____
_____
_____

How frequently would you like the child's counseling sessions to be scheduled?
☐ as needed ☐ 1x/month ☐ 2x/month ☐ 3x/month ☐ 4x/month ☐ don't know yet

Is everyone in the child's family aware of the concerns? ☐ Yes ☐ No
Is everyone in the family willing to participate in counseling? ☐ Yes ☐ No ☐ Don't know
Is there anything else the child's counselor should know? _____
_____
_____
_____
_____

My signature below indicates that I have completed this intake form with accurate data and I give Desert Streams Christian Counseling Services consent to render professional counseling services for the child that is indicated on this form.

Signature _____ Date _____