## Child and Adolescent Psychosocial History and Intake Assessment

**Date:**_____/_____/_____

**Client Legal Name:** _____ **Nick Name:** _____ **Age:** ___ **Gender:** ___ **Race:** _____

**Why are you seeking therapy services for your child:**

_____

_____

_____

**What are your primary goals for therapy, what do you want to see accomplished:**

1. _____
2. _____
3. _____

| Family Members in primary home | Relationship to Client and age of person | Family Members in secondary home | Relationship to Client and age of person |
|---|---|---|---|
| 1._____ | _____ | 1._____ | _____ |
| 2._____ | _____ | 2._____ | _____ |
| 3._____ | _____ | 3._____ | _____ |
| 4._____ | _____ | 4._____ | _____ |

**If parents are divorced what is the custody arrangement and visitation schedule. Is there a custody battle?**

_____

_____

**Occupations of all care givers:** _____

**Spiritual Beliefs:** _____

**Past Psychiatric History for your child:**

| Date | Type of care | | | Where/who provided these services | Reason you sought services |
|---|---|---|---|---|---|
| | Out patient | Acute | Residential | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Is there any family history for ☐ Anxiety☐ ADHD ☐ Bipolar ☐ Depression ☐ Schizophrenia ☐ Alcoholism ☐ Drug abuse**

**Explain:** _____

_____

**Past Medical History:**

**☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Head Injuries ☐ Seizures ☐ Medical Hospitalization ☐ Surgeries**

**☐ Other:**_____

**Present Medications/Dose/Effectiveness/Side Effects (including over the counter medications)**

_____

_____

**Past Medication/Dose/Effectiveness/Side Effects**

_____

_____

**Client Name** _____

**Birth/Developmental History:**

**Any complications during pregnancy: No Yes Explain:** _____

**At what age did your child do the following: Sitting ___ Walking ___ Talking ___ Toilet Trained ___**

**Does your child still have toileting accidents (enuresis and/or encopresis): No Yes How often:** _____

**Describe any sleep difficulties (falling asleep, staying asleep, won't sleep in own bed, nightmares, fear of dark, etc.)**

_____

_____

**What is your child's hobbies, interests, play activities, socialization activities, music, etc.**

_____

_____

**Describe How your child interacts with other children in and out of the home:** _____

_____

_____

**Describe how your child interacts with adults in and out of the home:** _____

_____

**Dating/Sexual Orientation/Pornography Use:**

**Sexual Orientation (circle): heterosexual homosexual bisexual**

**Are you concerned about promiscuity: Yes No**

**Does your child use pornography: Yes No**

**Do you monitor electronic devices: Yes No**

**Does your child date: Yes No**

**Any history of pregnancy: Yes No**

**Explain all Yes responses:** _____

_____

**Trauma History:**

**Is there now or in the past any allegations and/or findings of child abuse to include ☐ neglect ☐ physical ☐ sexual**

**Explain:** _____

_____

**Has this been reported to the authorities? Yes ___ No ___ If no please request reporting form.**

**Any other traumas (motor vehicle accident, witness/victim of crime, witness of domestic violence, victim of bullying, etc.)**

**Explain:** _____

_____

**School History**

**Current School:** _____ **Grade:** _____ **If ever held back/failed what grade:** ____

**Explain typical (past) verses current academic performance:** _____

**Classroom type(circle): regular advanced assisted classes (if assisted what subjects):** _____

**Behavior problems, suspensions, expulsions (explain):** _____

_____

_____

**If there has been a recent change in schools explain:** _____

_____

**Substance Use/Abuse**

**Substances used/frequency/duration:**

_____

_____