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Child/Adolescent Intake Form

Parents: To help your clinician better understand your child, please complete the following information **at least 48 hours** prior to you initial appointment. Please submit your intake to Dr. Taylor using **the "e-mail link" located at the end of this form**. Of note, all information provided is confidential.

Child's Legal Name: _____ Preferred Pronoun: _____

Date of Birth and Age: _____ Today's Date: _____

Form Completed by: _____ Relationship to Child: _____

Presenting Problem(s)/Reason for Treatment

What are your concerns regarding your child? _____

_____

_____

In what ways have these concerns impacted your child's life? _____

_____

_____

In what ways have these concerns impacted your family? _____

_____

What are some of the goals you have for your child while in treatment? _____

_____

_____

Did anyone refer you to Dr. Taylor? _____

If you were not referred, please tell us how you heard about Dr. Taylor? _____

Please Bold All that Apply:

☐ Sad or unhappy most of the time	☐ Inconsistent Following Directions	☐ Sleeping Difficulties
☐ Cries Frequently	☐ Talks Back to Adults/Authority Figures	☐ Overeating
☐ Lack of Energy	☐ Aggressive Behaviors	☐ Decreased Motivation for Food Intake
☐ Feelings of Worthlessness/Helpless	☐ Temper Outbursts	☐ Difficulty Concentrating
☐ Apathy	☐ Unmotivated	☐ Impulsive Behaviors/Reactions
☐ Negative Thinking	☐ Runs Away from Home	☐ Complaints of Aches and Pains
☐ Angry/Irritated Easily	☐ Often Swears	☐ Bites Nails/Pulls own Hair
☐ Loss of Previous Interests	☐ Often Lies	☐ Takes too Many Risks
☐ Thoughts Self Harm or Suicide	☐ Procrastinates	☐ Negative Body Image
☐ Vomiting	☐ Social Withdrawal	☐ Nervous Tics

☐ Immature	☐ Energetic	☐ Victim of Bullying
☐ Sensitive to Criticism	☐ Picks on other Kids	☐ Irritable
☐ Panic Attacks	☐ Lonely	☐ Victim of Cyberbullying
☐ Afraid of Rejection	☐ Anxious	☐ Gets into Physical Altercations with Peers
☐ Very Shy	☐ Cruel to Animals	☐ Isolates themselves
☐ Rapid Mood Changes Without Cause	☐ Perfectionist	☐ Tries to Boss Peers
☐ Restless	☐ Few or No Friends	☐ Overly Engaged in Video Games
☐ Emotionally Numb	☐ Fearful	☐ Overly Engaged with Social Media
☐ Optimistic	☐ Doesn't Trust Others	☐ Spends too much time Online
☐ Poor Loser	☐ Dating Problems	☐ Lives in a Blended Family

☐ Child of Divorced Parents	☐ Daydreams	☐ Struggles with Concentration
☐ Seeks out/needs a lot of Attention	☐ Easily Bored	☐ Easily Annoyed
☐ Has been in Trouble with the Law	☐ Seen as Different or Weird by Peers	☐ Content with How Things Are
☐ Drug Use Concerns	☐ Hates Going to School	☐ Afraid of Going to School
☐ Alcohol Use Concerns	☐ Learning Difficulties at School	☐ Problems Completing/Turning in Homework
☐ Steals	☐ Skips School Often	☐ Often Performs Below Ability in School
☐ Victim of Physical Abuse	☐ Victim of Emotional Abuse	☐ Victim of Sexual Abuse
☐ Has Difficulty with Pornography	☐ Frequency Migraines/Headaches	☐ Sees Things that Others Cannot See
☐ Unable to Relax	☐ Unable to Relax	☐ Unable to Relax

Are there any other concerns that are not listed above you would like to discuss/share? _____

_____

Race (Optional)

Mark Which Best Represents You Race:

American Indian or Alaska Native ___ Caucasian (White) ___ Asian ___ Black or African American ___

Native Hawaiian or Other Pacific Islander ___ Two or More Races __ Other: _____

Ethnicity (Optional)

Mark Which Best Represents Your Ethnicity:

Hispanic or Latino (Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race) ___

Non-Hispanic or Latino ___

Spanish Origin ___

Sexual Orientation (Optional)

Mark Which Best Represents Your Identified Sexual Orientation:

Heterosexual ___ Bicurious ___ Gay ___ Pansexual ___ Agender ___ Bisexual ___

Lesbian ___ Questioning ___ Androgyny/ous ___ Transgender ___ Demisexual ___

Third Gender ___ Asexual ___ Transitioning ___ Gender Fluid ___ Ze/Zir ___

Bigender ___ Queer ___ Intersex ___ Other _____

Family Relationships

Your Current Marital Status:

Married __ Separated (included living common law) ___ Single (included living common law)

Divorced (included living common law) ___ Domestic Partner (including living common law) ___

Never Married ___ Widowed (included living common law) ___

Please List any Family Member or Supportive Individual of Significance:

Name	Age	Relationship	Relationship Quality	Living with You
			Good __ Fair __ Poor __	Yes __ No __
			Good __ Fair __ Poor __	Yes __ No __
			Good __ Fair __ Poor __	Yes __ No __
			Good __ Fair __ Poor __	Yes __ No __
			Good __ Fair __ Poor __	Yes __ No __
			Good __ Fair __ Poor __	Yes __ No __
			Good __ Fair __ Poor __	Yes __ No __

Developmental History

Where you Born:

Premature (more than 2 weeks early) _____ Full Term (on time) _____ Late (how long) _____

Planned C-Section _____ Emergency C-Section_____

Any Complications at birth you can recall? (please list) _____

_____

During Pregnancy (mark all that apply):

High Stress ___ Illness ___ Hospitalization ___ Accidents ___ Domestic Violence/Trauma ___

Drug Use ___ Alcohol Use ___ Smoking (Cigarettes/Vaping etc.) ___ Chewing Tobacco ___

Bed Rest ___ Blood Loss ___ Gestational Diabetes ___ Other Illnesses: _____

As a Toddler, did you Experience: (mark all that apply)

Overly Active ___ Passive ___ Difficulty Separating from Parents ___ A Head Injury ___

Anxiety ___ Withdrawn ___ Sensitivity to: (clothing, light, texture, noise) ___ Nightmares ___

Any Change was Hard ___ Other: _____

Medical History

Do you have allergies? If yes, please list. _____

_____

Physical and/or Psych Hospitalizations? If yes, please list when and where. _____

_____

Serious Accidents of any kind? _____

_____

History of Head Injury with Loss of Consciousness? _____

_____

History of Repeated Strep Infections? If yes, please describe._____

_____

Current Medications: _____

_____

Current Primary Care Provider (if any): _____

Attended Therapy previously? Please list Therapist, Location, Reason Ended. _____

_____

_____

Do you Experience Issues with Pain? _____

Trauma History

Have you Ever Been a Victim of Abuse or Trauma: (mark all that apply)

Physical ___ Sexual ___ Bullying ___ Refugee Trauma ___ Medical Trauma ___

Emotional ___ Verbal ___ Neglect ___ National Disasters ___

Traumatic Greif ___ Community Violence ___ Terrorism and Violence ___ Other: _____

Personal and Family Psychiatric History

Please list Family Member, Diagnosis/Symptoms, When:

Family Member	Diagnosis/Symptoms	When

Is there a Family History of Learning Disabilities, Attention Deficit Hyperactivity Disorder, or Developmental Disorders? If yes, please list. _____

_____

Family History of Mania? If known please list. _____

Family History of Substance Abuse? _____

_____

Family History of Suicide? (attempted and/or completed) _____

_____

Personal Mental Health History:

Have you or do you currently engage in Self-Harm Behaviors? Please list method if comfortable doing so:

_____

Have you Expressed Thoughts of Suicide? If yes, please indicate when: _____

_____

Have you ever attempted Suicide? If yes, please indicate when and how: _____

_____

Have you ever Experienced Hallucinations and/or Delusions? Please Describe: _____

_____

Substance Use History

Do You Use: (mark all that apply. If occasional use, please indicate how often)

Alcohol ___
Cocaine ___
Marijuana ___
Marijuana Eatables ___
CBD Oil ___
Opioids ___
(Hydrocodone, Vicodin, Oxycodone, Percocet, Morphine, Codeine, Fentanyl, etc.)
Synthetic Cannabinoids (K2/Spice) ___
Smoke Cigarettes ___
Vape ___
Chewing Tobacco ___
Stimulants Recreationally (Adderall/Ritalin) ___
Methadone ___
Benzos (Xanax, Klonopin, Valium, etc.) ___

Systems

Average Hours of Sleep per night? _____ Do you Experience Nightmares? _____

More Challenging: (mark all that apply) To sleep ___ To Stay Asleep ___ To Wake up ___

Is your Bedtime Routine an Issue/Inconsistent? Please Explain: _____

_____

Recent Changes in Your: (mark all that apply) Mood ___ Eating Habits ___ Weight ___ Exercise ___

Educational History

Highest or Current Grade Level Completed: _____

Have you previously been Diagnosed with a Learning Disability? _____

Current Employer: _____ How long? _____

Employment Status:

Full Time (30 hours or more) ___ Unemployed ___ Volunteer ___ Internship ___

Part Time (Less than 30 hours) ___ Retired ___ Other (list) _____

Technology, Social Media and Video Game Play

Currently, how many hours per day do you spend:

Online (internet) ____ Playing Video Games ____ Watching YouTube ____ Watching TV ____

Streaming Movies/Shows (Netflix) ____ Using Social Media ____ Texting with Peers ___

Using Facetime ____

What Social Applications (Facebook, Instagram, Snapchat, etc.) do you use most? _____

_____

Legal

Any legal history of note? (Past, current, pending)_____

_____

Any Custody Related Legal History? _____

Any Family Legal History of Note? _____

Religious/Spiritual History

What religion or spiritual background do you ascribe to? Family ascribe to? _____

_____

How important is your religion and/or spiritual beliefs in your daily life? Family structure? _____

_____

Military History

Any Family Military Service of note? If so, please identify branch of service:

Family Member	Military Branch	Saw Combat
		Yes __ No __
		Yes __ No __
		Yes __ No __
		Yes __ No __
		Yes __ No __

Lastly, is there any other information/concerns about you and/or your family you would like me to know that would assist in treatment? _____

_____

_____

Client Signature: _____ Date: _____

Click here to email

Thank you in advance for taking the time to provide the above information!