The Counselors Miami

CHILD/ADOLESCENT INTAKE INFORMATION

Client Name: (First, M.I., Last)		
Birthdate:	Age:	Gender:
Address:		

Parent/Guardian Name: (First, M.I., Last)		
Relationship to Client: Mother/Father	Does the client live with you? Yes/No	Status: Married Divorced Single
Address if different from client:		

Child's Pediatrician:	
Child's Psychiatrist (if applicable)	

Parent Contact Information	**Number**	**May I contact you at this email or number?**
Email		Contact: Yes/No Message: Yes/No
Cell Phone:		Contact: Yes/No Message: Yes/No
Work Phone:		Contact: Yes/No Message: Yes/No

I am the custodial parent of this minor and/or have given proof that I can seek therapy for this client.

	Print Name	Signature (of parent/guardian)	Date
Client			
Parent/Guardian			

The Counselors Miami
CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY FORM

(Completed by the parent in regards to children 5 to 17 years of age)

Presenting Concerns:

Why are you bringing your child to counseling? _____

_____

When did you first notice these issues?_____

Have you previously sought help for this problem? Please explain: _____

_____

Please list any physical or psychological stressors in your child's life: _____

_____

Family Structure:

Please describe your child's family structure: (i.e. nuclear family, step-family, single parent home, non-custodial parent absent emotionally from child's life, grandparents living in home, grandparents raising the child, etc.)

_____

_____

Siblings: (Age, Sex):_____

Educational History:

Child's School_____Grade: _____

Does your child like school? Yes ____ No ____ If No please explain: _____

_____

Does your child have difficulty in a particular subject? Yes _____ No _____ If yes please explain: _____

_____

Does your child have a diagnosed Learning Disability? Yes _____ No _____ If yes please explain: _____

_____

Peer Relationships:

Does your child relate well with peers? Yes ____ No ____ If no please explain _____

_____

Does your child seek and is she/he sought by peers to play with? Yes_____ No ____ If No please explain: _____

_____

Social Media:

My child has a cell phone: Yes ____ No ____

My child has a computer/laptop: Yes ____ No ____

My child has the following social media accounts:

_____

I have passwords to these accounts and/or monitor my child's phone and laptop: Yes ____ No ____

Medical History:

Please check and explain if your child has had any of the following:

Issue:	√	**Explain:**
Childhood diseases	____	_____
Operations	____	_____
Hospitalizations	____	_____
Head Injuries	____	_____
Convulsions/seizures	____	_____
Vision Problems	____	_____
Hearing Problems	____	_____
Sleep Problems	____	_____
Appetite	____	_____
Abuse	____	_____
Suicide Attempts	____	_____

To the best of your knowledge does your child use illegal substances? Alcohol? Cigarettes and/or vaping? Etc?

Yes ___No___ If Yes please explain: _____

_____

To the best of your knowledge is your child sexually active? Yes ____ No ____ If yes please explain: _____

_____

Has your child had encounters with Law Enforcement? Yes ____ No ____ If yes please explain: _____

_____

Family Medical History: (please include extended family including parents, siblings, half-siblings, grandparents, cousins, uncles, aunts, if adopted biological parents, etc.)

Problem:	√	**Relationship to Child**	**Description of Problem**
Alcoholism	____	_____	_____
Drug Abuse	____	_____	_____
Psychological	____	_____	_____
Anger Issues	____	_____	_____
Suicides	____	_____	_____
Abuse	____	_____	_____

Medicines Your Child Is Taking:

	Name	Dosage	Times/Day	Condition	Physician
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Faith & Spirituality

As some clients find it helpful to include spiritual/religious beliefs in their counseling, please provide information as to your child's faith and spirituality background below if desired. My approach will be to honor your belief system and include it as you are comfortable.

_____

_____

_____

_____