vitalchanges

Science and Spirituality for Personal Transformation

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# INTAKE CHILD AND ADOLESCENT AGES UNDER 18

Client name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

**If you need any more space for any of the following questions please use the back of the sheet.**

Primary reason(s) for seeking services:

___ Anger management ____ Anxiety ____ Coping ____ Depression

___ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

___ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs ____ Hyperactivity

___ Other mental health concerns (specify): _____

_____

## Family History

### Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ___ Yes ___ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ___ Yes ___ No

If Yes, describe: _____

### Client's Mother

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? ___ Yes ___ No

___ Natural parent ___ Step-parent ___Adoptive parent __Foster home ___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

___ Yes ___ No If Yes, please explain: _____

_____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

**Client's Father**

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? __ Yes ___ No

__ Natural parent ___ Step-parent ___Adoptive parent __Foster home ___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

__ Yes ___ No If Yes, please explain: _____

_____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

**Client's Siblings and Others Who Live in the Household**

| Names of Siblings | Age | Gender | Lives | Quality of relationship with the client |
|---|---|---|---|---|
| _____ | ___ | ___ F ___ M | ___ home ___ away | ___ poor ___ average ___ good |
| _____ | ___ | ___ F ___ M | ___ home ___ away | ___ poor ___ average ___ good |
| _____ | ___ | ___ F ___ M | ___ home ___ away | ___ poor ___ average ___ good |
| _____ | ___ | ___ F ___ M | ___ home ___ away | ___ poor ___ average ___ good |
| Others living in the household | | | Relationship (e.g., cousin, foster child) | |
| _____ | ___ | ___ F ___ M | _____ | ___ poor ___ average ___ good |
| _____ | ___ | ___ F ___ M | _____ | ___ poor ___ average ___ good |
| _____ | ___ | ___ F ___ M | _____ | ___ poor ___ average ___ good |
| _____ | ___ | ___ F ___ M | _____ | ___ poor ___ average ___ good |

Comments: _____

_____

_____

**Family Health History**

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

| | | |
|---|---|---|
| __ Allergies | ___ Deafness | ___ Muscular Dystrophy |
| __ Anemia | ___ Diabetes | ___ Nervousness |
| __ Asthma | ___ Glandular problems | ___ Perceptual motor disorder |
| __ Bleeding tendency | ___ Heart diseases | ___ Mental Retardation |
| __ Blindness | ___ High blood pressure | ___ Seizures |
| __ Cancer | ___ Kidney disease | ___ Spinal Bifida |
| __ Cerebral Palsy | ___ Mental illness | ___ Suicide |
| __ Cleft lips | ___ Migraines | ___ Other (specify): _____ |
| __ Cleft palate | ___ Multiple sclerosis | _____ |

Comments re: Family Health: _____

_____

## Childhood/Adolescent History

**Pregnancy/Birth**

Has the child's mother had any occurances of miscarriages or stillborns? ___ Yes ___ No

If Yes, describe: _____

Was the pregnancy with child planned? __ Yes ___ No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number ___ of __ total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? ___ Yes ___ No If Yes, what amount: _____

Did the mother use drugs of alcohol? ___ Yes ___ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) ___ Yes ___ No

If Yes, describe: _____

Length of labor: _____ Induced: ___ Yes ___ No Caesarean? ___ Yes ___ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

**Infancy/Toddlerhood** Check all which apply:

| | | | |
|---|---|---|---|
| __ Breast fed | ____ Milk allergies | ___ Vomiting | ____ Diarrhea |
| __ Bottle fed | ____ Rashes | ___ Colic | ____ Constipation |
| __ Not cuddly | ____ Cried often | ___ Rarely cried | ____ Overactive |
| __ Resisted solid food | ____ Trouble sleeping | ___ Irritable when awakened | ____ Lethargic |

**Developmental History** Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: __ slow ____ average ____ fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

**Education**

Current school: _____ School phone number: _____

Type of school: ___ Public ___ Private ___ Home schooled ___ Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? ___ Yes ___ No If Yes, describe: _____

In gifted program? ___ Yes ___ No If Yes, describe: _____

Has child ever been held back in school? ___ Yes ___ No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? __ Yes ___ No

If Yes, describe: _____

Has the child been tested psychologically? ___ Yes ___ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

**Feelings about School Work:**

__ Anxious ___ Passive ___ Enthusiastic ___ Fearful

__ Eager ___ No expression ___ Bored ___ Rebellious

__ Other (describe): _____

**Approach to School Work:**

__ Organized ___ Industrious ___ Responsible ___ Interested

__ Self-directed ___ No initiative ___ Refuses ___ Does only what is expected

__ Sloppy ___ Disorganized ___ Cooperative ___ Doesn't complete assignments

__ Other (describe): _____

**Performance in School (Parent's Opinion):**

__ Satisfactory ___ Underachiever ___ Overachiever

__ Other (describe): _____

**Child's Peer Relationships:**

__ Spontaneous ___ Follower ___ Leader ___ Difficulty making friends

__ Makes friends easily ___ Long-time friends ___ Shares easily

__ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ___ Mother ___ Father ___ Shared ___ Other (specify): _____

Health: ___ Mother ___ Father ___ Shared ___ Other (specify): _____

Problem behavior: ___ Mother ___ Father ___ Shared ___ Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ___ Poor ___ Average ___ Good ___ Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? ___ Lower ___ Same ___ Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

**Leisure/Recreational**

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

| Activity | How often now? | How often in the past? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Medical/Physical Health**

| | | |
|---|---|---|
| ___ Abortion | ____ Hayfever | ____ Pneumonia |
| ___ Asthma | ____ Heart trouble | ____ Polio |
| ___ Blackouts | ____ Hepatitis | ____ Pregnancy |
| ___ Bronchitis | ____ Hives | ____ Rheumatic Fever |
| ___ Cerebral Palsy | ____ Influenza | ____ Scarlet Fever |
| ___ Chicken Pox | ____ Lead poisoning | ____ Seizures |
| ___ Congenital problems | ____ Measles | ____ Severe colds |
| ___ Croup | ____ Meningitis | ____ Severe head injury |
| ___ Diabetes | ____ Miscarriage | ____ Sexually transmitted disease |
| ___ Diphtheria | ____ Multiple sclerosis | ____ Thyroid disorders |
| ___ Dizziness | ____ Mumps | ____ Vision problems |
| ___ Ear aches | ____ Muscular Dystrophy | ____ Wearing glasses |
| ___ Ear infections | ____ Nose bleeds | ____ Whooping cough |
| ___ Eczema | ____ Other skin rashes | ____ Other |
| ___ Encephalitis | ____ Paralysis | _____ |
| ___ Fevers | ____ Pleurisy | |

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

**Nutrition**

| Meal | How often (times per week) | Typical foods eaten | Typical amount eaten |
|---|---|---|---|
| Breakfast | ____ / week | _____ | ____ No __ Low ____ Med ____ High |
| Lunch | ____ / week | _____ | ____ No __ Low ____ Med ____ High |
| Dinner | ____ / week | _____ | ____ No __ Low ____ Med ____ High |
| Snacks | ____ / week | _____ | ____ No __ Low ____ Med ____ High |

Comments: _____

**Most recent examinations**

| Type of examination | Date of most recent visit | Results |
|---|---|---|
| Physical examination | | |
| Dental examination | | |
| Vision examination | | |
| Hearing examination | | |

| Current prescribed medications | Dose | Dates | Purpose | Side effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Current over-the-counter meds | Dose | Dates | Purpose | Side effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Immunization record (check immunizations the child/adolescent has received):

| | DPT | Polio |
|---|---|---|
| 2 months | ___ | ___ |
| 4 months | ___ | ___ |
| 6 months | ___ | ___ |
| 18 months | ___ | ___ |
| 4–5 years | ___ | ___ |

15 months ___ MMR (Measles, Mumps, Rubella)
24 months ___ HBPV (Hib)
Prior to school ___ HepB

**Chemical Use History**

Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes ___ No

If Yes, describe: _____

**Counseling/Prior Treatment History**

Information about child/adolescent (past and present):

| | Yes | No | When | Where | Reaction or overall experience |
|---|---|---|---|---|---|
| Counseling/Psychiatric treatment | ___ | ___ | | | |
| Suicidal thoughts/attempts | ___ | ___ | | | |
| Drug/alcohol treatment | ___ | ___ | | | |
| Hospitalizations | ___ | ___ | | | |

**Behavioral/Emotional**

Please check any of the following that are typical for your child:

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries excessively
___ Other: _____
_____

Please describe any of the above (or other) concerns: _____

_____

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Has the child/adolescent experienced death? (friends, family pets, other) ___ Yes ___ No
At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)
___ Yes ___ No If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist us in understanding current concerns or problems?

_____

_____

_____

What are your goals for the child's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? _____ Yes _____ No
If Yes, explain: _____

_____

**For Staff Use**

Therapist's comments: _____

_____

_____

_____

_____

Therapist's signature/credentials: _____ Date: _____/____/_____

Supervisor's comments: _____

_____

_____

_____

_____ Physical exam: _____ Required ___ Not required

Supervisor's signature/credentials: _____ Date: _____/____/_____
(Certifies case assignment, level of care and need for exam)

**Billing Information**

Client Name: _____ Date of Birth: _____

Address: _____

☐ Home phone: _____ ☐ Work phone: _____

☐ Cell phone: _____ ☐ Email: _____
[√ Check preferred contact numbers]

INSURANCE COMPANY: _____

POLICY NUMBER:_____ GROUP NUMBER: _____

NAME OF INSURED: _____

SECONDARY INSURANCE COMPANY: _____

POLICY NUMBER:_____ GROUP NUMBER: _____

NAME OF INSURED: _____

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.
I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____ Date: ____/____/_____

**Release of Information Authorization to Third Party**

I (we) authorize **Dr. David McFarlane** to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to **Dr. David McFarlane and Vital Changes, Inc** .

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: ____/____/_____

Person(s) receiving services: _____ Date: ____/____/_____

Person(s) or guardian(s): _____ Date: ____/____/_____

_____

Signature: _____ Date _____