**E. Carrington's Counseling Clinic**
**A program of Calvary Counseling Center**
**9300 Forest Point Circle**
**Manassas, VA 20110**
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# CHILD AND ADOLESCENT INTAKE FORM
## For Ages 4 & Up

Child's Name ______________________________________________ Date of Birth: ______________
Address: __________________________________________________ SSN: ______________________
City, State, Zip: _________________________________________________________________________
Last grade completed in school: ___________________________ Grade Average: ____________________
Name of School: ____________________________________________________________________________

Mother's Name: ____________________________________________ Date of Birth: ________________
Address: __________________________________________________ SSN: ________________________
City, State, Zip: ___________________________________________ Highest Grade Completed: _________
Occupation: __________________________________ Place of Employment: _________________________
Home Phone: __________________ Work Phone: ___________________ Cell Phone: ___________________
E-Mail Address: ______________________________________ Religious Affiliation: _____________________

Father's Name: ____________________________________________ Date of Birth: ________________
Address: __________________________________________________ SSN: ________________________
City, State, Zip: ___________________________________________ Highest Grade Completed: _________
Occupation: __________________________________ Place of Employment: _________________________
Home Phone: __________________ Work Phone: ___________________ Cell Phone: ___________________
E-Mail Address: ______________________________________ Religious Affiliation: _____________________

Step-Parent/ Guardian's Name: __________________________________ Date of Birth: ________________
Address: ______________________________________________________ SSN: ________________________
City, State, Zip: ___________________________________________ Highest Grade Completed: _________
Occupation: __________________________________ Place of Employment: _________________________
Home Phone: __________________ Work Phone: ___________________ Cell Phone: ___________________
E-Mail Address: ______________________________________ Religious Affiliation: _____________________

Siblings

| Name | Age | In/Out of Home | Guardian |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Other Household Members

| Name | Age | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

Please describe the presenting problem:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

List your child's interests/hobbies/skills: _____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What languages are spoken in home? ________________ How many homes has the child lived in? _______
With whom does the child share a bedroom and/or bed? ____________________________________
Who cares for the child during the day? _________________________________________________
In what year were the natural parents married? ___________________________________________
How many years were parents married before the birth or adoption of 1st child? ________________
In what year were the parents separated, if applicable? _______________ Divorced? _____________
Who has legal custody of the child? ___________________________________________________
Are you authorized to seek counseling for this child? ____ Yes _____ No
In what year was the custodial parent remarried, if applicable? ______________________________
This child is: ______ natural ______ adopted. List any known problems encountered during this pregnancy:
____________________________________________________________________________________
____________________________________________________________________________________
What was child's birth weight? ___________
Were eating habits ____ regular ____ irregular? Were sleeping habits ____ regular ____ irregular?
If irregular, please explain ________________________________________________________
____________________________________________________________________________________

What was child's approach to new situations: _____Positive _____ Withdrawn _____ Slow to warm-up
What was child's reaction to new stimuli? _____ Intense _____ Moderate _____ Little or None
When trying new things or encountering new situations, regardless of your child's initial reaction, would you describe your child as ____ Adaptable ____ Slow to Adapt ____ Unadaptable
Your child's activity level would be described as: ____ Extreme ____ Moderate ____ Quiet

At what age was toilet training started? _____________ At what age was it established? _______________
Describe any struggles, if any, with toilet training
____________________________________________________________________________________
____________________________________________________________________________________
Does your child ever wet the bed? ____ Yes ____ No If so, how often? _________________________
Does your child ever soil or have toileting accidents? ___ Yes ___ No If so, where is the child when soiling or wetting occurs? ______________________________ Does it occur ___ Night ___ Day ___ Both?

How is discipline handled in the home? _________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Describe any traumatic events that your child has been through (deaths, abuse, moves, etc.)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Past Consultations: Have you contacted counselor/psychologist/psychiatrist in the past? ___ Yes ___ No
If so, what was the outcome? ______________________________________________________

Is your child on medication? ___ Yes ___ No If yes, please list medications and dosage: _____________
_______________________________________________________________________________________
_______________________________________________________________________________________
Is your child attending school? ____ Yes ____ No? Is your child expected to ____ Pass ____ Fail this year?
What special services, if any, is your child receiving in school? In what subjects and for how many hours per day? _______________________________________________________________________________________
_______________________________________________________________________________________
Has your child ever failed a class or been held back? ___ Yes ___ No If yes, please describe: _____________
_______________________________________________________________________________________
Is your child presently receiving counseling in the school? ___ Yes ___ No
If yes, from whom? ____________________________ Phone number: ____________________________
May we contact him/her? ___ Yes ___ No

List your child's interests/hobbies/skills: _________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Please list any additional information which you feel we should know about:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Referral Information:
How did you find us (referred by doctor, friend, family, church, other)? _____________________________
_______________________________________________________________________________________

Insurance Information:
Insurance Company: _________________________________ Policy/Group #: _________________________
Address: __________________________________________ Phone number: _________________________
___ PPO ___ HMO Has deductible been met? _______________

Parent/Guardian Signature: ___________________________________________ Date: _________________

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For Office Use Only

Self – Pay: ___ Yes ___ No If so, appointment fee? ___________

Appropriate for group ___ Yes ___ No

Referral Source: ___________________________________

Axis I:________________(P)
________________(S)
Axis II: ________________
Axis III: _______________
Axis IV: _______________
Axis V: _______________

Paperwork Requested ___ Yes ___ No How often? ___ Monthly ___ Quarterly

Appointment Schedule _____ Mon ____ Tues ____ Wed ____ Thurs ____ Sat Time: _____ __ AM __ PM
___ Weekly ___ Bi-Weekly

Assessment Due Date: _____________________________ Treatment Plan Review Date: _________________