Jessica Davidson

Licensed Professional Counselor | Child & Adolescent Therapy

Initial Therapy Intake Form

Client Information:

Child's Name_____Sex__M or F__
Age_____ Date of Birth_____ Social Security Number_____
Home Address_____
Parent/Guardian _____/Relationship_____
Phone_____ or _____
Emergency Contact Person_____/Relationship_____
Phone_____ or _____
How did you hear about my counseling services? _____

Therapy Goals and Client Stressors

What do you wish to achieve through therapy at this time?_____
_____
_____
_____
_____

Briefly describe the history of this problem. _____
_____
_____
_____
_____

Presently, and during the last two years, what are/have been some of the stressful events in your child's life (death of a loved one, family difficulties, parental divorce/separation, physical/sexual abuse, social difficulties, etc)?

_____
_____
_____
_____

How does your child usually handle stressful events? (i.e.: effective coping skills, ineffective coping skills, dangerous or harmful behaviors, acting out, isolating, etc):

_____
_____
_____
_____

Does your child have a history of trauma or abuse (victim of or witness to physical or sexual abuse, domestic violence, traumatic losses, etc). If yes, please describe:

_____
_____
_____

Medical/Mental Health History:

Any Previous Therapy/Counseling: _____
If yes, what type of therapy and how long did your child attend?

_____

_____

Was therapy beneficial to your child? Why did you feel it helped/didn't help? _____

_____

_____

Is your child currently in treatment with any other counselor or psychiatric provider? _____
Medical Problems (describe):_____
History of any hospitalizations (medical and/or psychiatric):_____

_____

Name of Primary Care Physician:_____Phone:_____
Name of Psychiatrist (if applicable): _____Phone: _____

Suicide Information:	**Check all that apply:**
None: no suicidal thoughts	•My child has never had thoughts of suicide
Mild: some thoughts, no plan	• My child is experiencing these thoughts now • My child has experienced these thoughts in the past. • My child last experienced this on: Date:_____
Moderate: some thoughts, vague plan, low levels of lethality	• My child is experiencing these thoughts now • My child has experienced these thoughts in the past • My child last experienced this on: Date:_____
Severe: significant thoughts, plan is specific and lethal	• My child is experiencing these thoughts now • My child has experienced these thoughts in the past • My child last experienced this on: Date:_____

Has your child ever actually attempted suicide at any time in his/her life? **Yes / No**
If yes, when and describe the circumstances leading up to the attempt as well as follow-up after the attempt:

_____

_____

_____

_____

Your Child's Substance Use/Addiction History

Prescription Drug Use (Current names and doses): _____
_____
Previous Prescription Drug Use (names and doses): _____
_____
Any side effects?_____
History of Illegal Drug use? (describe):_____
Current Illegal Drug use? (describe): _____
Alcohol use/abuse (describe frequency and reason for use):_____
_____
Does your child struggle with other addictive behaviors (overeating, obsessive activities, etc.)? If yes, please describe.
_____
_____

Symptom Assessment:

Check all of the following that apply to your child over the last two weeks.

Emotional Symptoms-

__ anger
__ irritability
__ hopelessness
__ depression
__ feelings of inferiority
__ guilt
__ other (specify) _____
__ anxiety
__ worrying
__ helplessness
__ apathy
__ panicky
__ unable to have a good time
__ extreme mood shifts
__ frustration
__ fears
__ lack of emotions

Cognitive Symptoms-

__ problems with concentration
__ difficulty making decisions
__ racing thoughts
__ repeated unwanted thoughts
__ recurring nightmares
__ inattention
__ distractibility
__ memory problems
__ hallucinations
__ other _____

Physical Symptoms-

__ increase or decrease in appetite
__ tearfulness/crying spells
__ sweating/chills
__ stomach or intestinal distress
__ sleep difficulties
__ dizziness/fainting
__ shaky hands/feet
__ racing heart rate
__ body pain/numbness
__ frequent or severe headaches
__ muscle tension
__ other _____

Behavioral Symptoms-

__ hyperactivity
__ suicidal gesture/attempt history
__ verbal aggression
__ social withdrawal
__ self-injury
__ disorganization
__ lying/deceitfulness
__ avoidance of school or job
__ relationship problems
__ impulsivity
__ present suicidal thoughts
__ physical aggression
__ induced vomiting
__ increased alcohol/drug use
__ oppositional/defiant
__ sexual problems
__ binge eating/overeating
__ other_____

Upon my signature below, I hereby attest that all the information furnished is true and correct.

_____ _____
Client Signature (if completed by client) **Date**

_____ _____
Signature of Legal Guardian of Client under the age of 16 **Date**

_____ _____
Therapist Signature **Date**