Client Name _____

Arrow Counseling Services, LLC

CONFIDENTIAL CHILD (13 yrs old and younger) CLIENT INTAKE FORM

Please bring this completed form to your first appointment. All information contained herein is confidential in accordance with the attached policies and procedures and in accordance with the HIPAA Privacy Act. This information is requested to obtain the best level of treatment and care possible.

Name: _____

Address: _____ Date of Birth _____

_____ Gender: Male Female (Circle One)

SS#: _____ Age:_____

How would you like me to contact you? May we leave a message at this contact number? (Please circle response)

Home:	yes or no	Phone:
Work:	yes or no	Phone:
Cell phone:	yes or no	Phone:
Email:	yes or no	Email address:
Other:		

Name of person completing form: _____

Relationship to person receiving services: _____

Special Needs

1. Do you have a need for Assistive Technology (interpreter, verbal instructions, etc.) in the Provision of Services? Yes No
   If yes, Describe:_____
2. Do you have any other disabilities, disorders or concerns in this area? Yes No

   If yes, Describe:__ _____

Presenting Problems

1. Please describe in detail the issues that have brought you to counseling:

_____
_____
_____

Client Name _____

PROBLEM BEHAVIORS

Please check any of the behaviors which occur **excessively** or **frequently** now and/or in the **past**.

Symptoms Experienced in the last **two (2) weeks**	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	If longer than 2 weeks please indicate the # of weeks, months, years
Accident prone						_____ W, M, Y
Argues						_____ W, M, Y
Bed wetting						_____ W, M, Y
Boredom						_____ W, M, Y
Bullies						_____ W, M, Y
Compulsive repetitive behaviors						_____ W, M, Y
Cruelty to animals						_____ W, M, Y
Crying						_____ W, M, Y
Decreased appetite						_____ W, M, Y
Defiant, oppositional						_____ W, M, Y
Depression						_____ W, M, Y
Destroys property						_____ W, M, Y
Disruptive behavior						_____ W, M, Y
Distractible						_____ W, M, Y
Disturbing thoughts						_____ W, M, Y
Fears						_____ W, M, Y
Fights						_____ W, M, Y
Frequent physical complaint						_____ W, M, Y
Hyperactive						_____ W, M, Y
Impulsive						_____ W, M, Y
Increased appetite						_____ W, M, Y
Insomnia						_____ W, M, Y
Irritable						_____ W, M, Y
Learning problems						_____ W, M, Y
Legal problems						_____ W, M, Y
Lies						_____ W, M, Y
Messy						_____ W, M, Y
Missing school due to illness						_____ W, M, Y
Mood swings						_____ W, M, Y
Night mares						_____ W, M, Y
Night terrors						_____ W, M, Y
Obsessive thoughts						_____ W, M, Y
Odd behaviors						_____ W, M, Y
Odd thoughts						_____ W, M, Y
Poor grades						_____ W, M, Y
Reckless/careless						_____ W, M, Y
Runs away from home						_____ W, M, Y
Sadness						_____ W, M, Y
Sexual activity						_____ W, M, Y

Short attention						_____ W, M, Y
Skipping classes, school						_____ W, M, Y
Sleepwalking						_____ W, M, Y
Speech problems						_____ W, M, Y
Steals						_____ W, M, Y
Tantrums, angry outbursts						_____ W, M, Y
Thumb sucking						_____ W, M, Y
Will not sleep alone						_____ W, M, Y
Withdrawn						_____ W, M, Y
Worries						_____ W, M, Y
						_____ W, M, Y

1. Any **history** of thoughts/plans/acts/ideation or intention of suicide? Yes No
If yes, circle all that apply: Passive Thoughts Single Attempt Multiple Attempts
If yes, explain: _____
_____

2. Do you **currently** have any thoughts/plans/acts/ideation or intention of suicide? Yes No
If yes, describe: _____
_____

3. Any **history** of thoughts/plans/acts/ideation or intention of homicide? Yes No
If yes, circle all that apply: Passive Thoughts Violence Towards Another
If yes, explain: _____
_____

4. Do you **currently** have any thoughts/plans/acts or intention of homicide? Yes No
If yes, describe: _____

If you answered yes to the above questions, what things happen that make you want to harm yourself or others?
_____
_____

Parent/ Guardian Family Information

PARENT 1: Mother

Name:_____ Date of Birth: _____

Address 1: _____ Home Phone/Cell Phone:_____

Address 2: _____ Work Phone:_____

Email Address:_____ Highest Grade Completed _____

Occupation: _____Place of Employment _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Date of Separation/ Divorce / Widowed (if applicable) _____

Military Experience

Have you ever served in the military? Yes No If Yes, Please describe your military experience:

_____

PARENT 2: Father

Name:_____ Date of Birth: _____

Address 1: _____ Home Phone/Cell Phone:_____

Address 2: _____ Work Phone:_____

Email Address:_____ Highest Grade Completed _____

Occupation: _____Place of Employment _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Date of Separation/ Divorce / Widowed (if applicable) _____

Military Experience

1. Have you ever served in the military? Yes No If Yes, Please describe your military experience:

_____

Sibling Information:

NAME	DATE OF BIRTH	RELATIONSHIP (full/half sib, foster, biological, adopted)	CURRENTLY LIVING (home, school, with other family)

Others Living in the Home

NAME	AGE	GENDER	RELATIONSHIP

With whom has the child lived in the past?

DATES	TYPE OF PLACEMENT	NAMES OF CAREGIVERS	REASON FOR MOVE

***Type of placement: Birthparents, birth relatives, foster parents, adoptive parents, step parents, group home, residential treatment center, other.**

Custody Information

1. Who has legal custody of the child?
   _____

2. With whom is the child currently living?
   _____

3. If the child is adopted, what factors led to parent(s) decision to adopt?

_____

_____

_____

_____

4. Does the noncustodial parent:

Know of this Evaluation	YES	NO
Have Regular/Frequent Contact with Son/Daughter	YES	NO
Have Limited/Unpredictable Contact	YES	NO
Insure the Child/Adolescent	YES	NO

5. If the child/adolescent does not live with biologic or adoptive parent(s), please provide the following information regarding guardianship. Are you:

   ☐ Foster Parent(s)
   Foster Parent/Guardian's Name: _____

   Address: _____ Phone: (____)_____

   _____ Zip Code: _____

   ☐ A legal guardian(s) who is a biologic relative: State relationship _____

   ☐ A legal guardian(s) who is not a biologic relative

6. Please state why child/adolescent is in foster care or with a guardian

_____

_____

Client Name _____

Child/Adolescent Birth and Development History

1. Age of birthmother at time of child's birth: _____ Birthmother's total number of pregnancies _____
2. This child was pregnancy #_____ Miscarriages _____ Abortions: _____
3. Did Birthmother have prenatal care? _____ When? _____
4. Was mother depressed during the pregnancy?
   _____
5. Was mother ambivalent about the pregnancy? _____ If so, why?
   _____

Problems during pregnancy with this child/adolescent:

☐ None ☐ Unusual swelling ☐ Unusual weight gain If yes, how much? _____ ☐ Unusual weight loss If yes, how much? _____ ☐ High blood pressure ☐ Infections ☐ Bleeding ☐ Unusual vomiting ☐ Smoking during pregnancy ☐ Alcohol use ☐ Use of street drugs	☐ Medications taken during pregnancy (please list names and reason for taking) _____ _____ _____ ☐ Disease or exposure to contagious disease (please explain) _____ _____ _____ ☐ Persistent emotional stress, depression or anxiety (please explain) _____ _____ _____

6. Was father supportive during the pregnancy? _____.
   If not, why?
   _____
7. Did childbirth occur between 38 and 40 weeks? _____. Any complications during delivery? _
   _____
8. Was the infant diagnosed with in-utero alcohol exposure? _____.
9. Was the infant diagnosed with in utero drug exposure? _____. If yes, to which drugs?
   _____
10. Did examination at birth reveal any physical disorders? If so, please explain:

_____

_____

11. Mother's health after childbirth was good _____, poor _____. If poor, please explain:
    _____
12. On what day in the hospital did mother first see the baby? _____

13. Did mother hold the baby? _____. If so, on what day? _____

14. How long were mother and baby in the hospital before coming home? _____

15. Were there any problems with the child in the hospital before coming home?

    _____

16. How did the mother respond to the child's fussiness?

    _____

During infancy, were any of the following present?

☐ Weak crying response ☐ Constant whining ☐ Rageful crying ☐ Extremely sensitive to touch ☐ Extremely resistant to cuddling ☐ Limp when held ☐ Stiff when held ☐ Arched back and resisted to being held ☐ Poor sucking response	☐ Poor eye contact, lack of tracking with eyes ☐ No reciprocal smile response ☐ Indifference to others ☐ Choked easily ☐ Vomited or spit up frequently ☐ Unusually nervous or jittery ☐ Child had colic till age: _____	☐ Difficulty chewing ☐ Held breath for long periods of time ☐ Had allergic reactions to: _____ _____ ☐ Other: _____ _____ _____ _____

At what age did the following occur?

Smiling: _____ Sat without support: _____ Walked alone: _____ Spoke first word: _____ Used 2 or 3 word sentences: _____ Was completely weaned: _____	Started toilet training: _____ Completed toilet training: (bladder)_____ Completed toilet training: (bowel) _____ Relapses of bladder or bowel control: _____ Completely dressed him/herself:_____ Tied shoes: _____

17. Was the above information from your baby book, diary, reports or memory?

    _____

18. If child was abused, neglected, or institutionalized, please describe the child's experiences (if known):

_____

_____

Physical Development

1. **Please describe the child's large muscle development (e.g. walking, hopping, skipping, riding a bicycle):**

_____

_____

2. **Please describe the child's small muscle development (e.g. using a pencil, doing puzzles):**

_____

_____

3. **Which hand does the child prefer to use? _____ Is preference consistent? _____**
4. **Is the child's speech normal? _____ If not, please describe:**

   _____
5. **Has the child ever had speech therapy? _____. If so, please describe:**

   _____
6. **Is the child's hearing normal? _____ If, not please describe:**

   _____
7. **Has the child received vision therapy? _____ If so, please describe:**

   _____

SUBSTANCE USE

1. Has your child/adolescent ever used any substances? Please check all that apply:

Drugs, Alcohol, or Substances:

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								

If yes to any of the above, please explain _____

Client Name _____

Medical Information

	Name	Phone number		
Primary Care Physician			Yes	No
Psychiatrist			Yes	No
Caseworker			Yes	No
Case Manager			Yes	No
Other MH Therapist			Yes	No

1. Please list all other Health Care Providers: May we contact them to coordinate care?

2. Please list the child's medications below: (Beginning with current medications and working backwards):

Dates	Name of Medication	Amount (ex 10 mg)	Taken When:	Prescribed by:	Side Effects/Reactions

3. Weight _____lbs Height_____ BMI_____

4. Any allergies or special precautions? Yes No Unknown

If yes, *circle all that apply*:
Seasonal Medications Food Latex Animals Other
If yes, specify: _____
_____

Social Adjustments

1. How would you describe your child's interactions with others (parents, teachers, peers, siblings, relatives)

_____

_____

_____

_____

Client Name _____

	Gets along well	Avoids	Aggressive	Clings	Other
Parents					
Mom					
Dad					
Siblings					
Teachers					
Relatives					
Peers					

Education

1. Please list all schools attended beginning with current school:

Dates & Grades Attended	Name of School	Address/Telephone Number	Behavior Problems (If any)

2. Does your child enjoy being in school? Specific likes and dislikes:

_____

_____

3. Has your child been diagnosed with learning disabilities? If so, please indicate:

_____

_____

Client Name _____

Cultural, Gender and Spiritual Information

1. Primary cultural/ethnic group?

   Caucasian Hispanic/Latino African American Asian Jewish
   Middle Eastern Native American Arab European
   Other- _____

2. Any Gender and/or Sexual Orientation Issues? Yes No
   If yes, describe issues: _____
   _____

3. Primary Religious Affiliation *Circle any that apply:*
   Baptist Buddhist Catholic Episcopalian Hindu
   Lutheran Methodist Muslim Non-denominational Protestant
   Jewish Other Non-Christian None Other-Christian
   Other: _____

4. What are your spiritual beliefs and practices?
   _____
   _____

5. How often are you involved in religious or spiritual practices? *Circle all that apply*
   Regular Involvement Occasional Involvement
   Special Celebrations/Holiday Involvement No Involvement

6. Do you have spiritual strengths? No Yes Please describe_____

_____

7. Do you have spiritual problems? No Yes Please describe_____

_____

Treatment History

Professional Counseling or Therapy	Dates	Therapist's Name/Address & Phone	Type (Individual. Family)	Results

5. Did you have a positive experience in your previous treatment? Yes No

6. Were you compliant with previous treatment? Yes No

Client Name _____

Trauma

1. **Has your child/adolescent witnessed any Domestic Violence?** ☐ **NO** ☐ **Yes, if so: Please explain:**

_____

_____

2. **Has your child experienced any trauma? (Ex. Domestic violence, sexual abuse, physical abuse, witnessed a car accident, parent die, ect.)** ☐ **No** ☐ **Yes If so, please explain:**

_____

_____

3. **What was your child's reaction to the trauma? Please explain:**

_____

_____

4. **Did your child receive any treatment to address the effects of the trauma? If so, please explain:**

_____

Legal and Military History

1. Has your child/adolescent ever had a history of legal charges? Yes No
   If yes, please explain _____
   _____
2. Is your child/adolescent currently on probation? Yes No
   If yes, please explain terms of probation _____
   _____
3. Has your child/adolescent been involved with the military? Yes No
   If yes, please explain _____

STRENGTHS/WEAKNESSES/ BARRIERS TO TREATMENT

1. Please list your strengths: *Circle all that apply*:

Affectionate	Ambitious	Artistic	Athletic	Brave	Calm
Cheerful	Considerate	Creative	Dependable	Drug-free	Easy-Going
Efficient	Energetic	Forgiving	Humorous	Hardworking	Insightful
Honest	Humble	Independent	Intelligent	Kind	Likeable
Loyal	Mature	Open-minded	Organized	Outgoing	Patient
Active	Attractive	Healthy	Strong	Tough	Prayerful
Professional	Reflective	Relaxed	Religious	Reserved	Resourceful
Responsible	Sensitive	Serious	Stable	Sympathetic	Tactful
Adventurous	Tolerant	Trustworthy	Warm	Wholesome	Wise

Other:_____

2. Describe any leisure activities or hobbies: *Circle all that apply*

Hunting/Fishing	Spending Time with Family	Playing on the Computer	Church Activities
Reading	Cooking	Working Outside	Playing with Friends
Exercising	Sports	Water Activities	Other

Comments:_____ _____
_____
_____

3. Who makes up your current support system? *Circle all that apply:*

Boy/Girlfriend	Parents	Classmates	Extended Family
Friends	Siblings	None	Religious Organization
Self-help Group	Social Service Group	Teachers	Other:_____

4. How do you cope with life events and daily stress? Please check all that apply

☐ Talk to family	☐ Talk to support group	☐ Other _____
☐ Talk to friends	☐ Resources on internet	☐ Other _____
☐ Pray	☐ Journal	☐ Other _____
☐ Talk with professional	☐ Yoga/Exercise	☐ Other _____

5. Are there any **barriers or challenges** to treatment and to change? Yes No
If yes, *circle all that apply*

Anger	Aggression	Childcare	Cultural Beliefs
Family Members	High Anxiety	Unstable Living Conditions	Medical Complications
Memory Impairment	Pregnancy	Past Treatment Experience	Religious Beliefs
Severe Depression	Substance Use	Medication Side Effects	Transportation
Work Schedule	Other: _____		

Explain: _____
_____

Initial Goals for Treatment:

1. _____
2. _____
3. _____

I have answered truthfully and to the best of my ability regarding all of the information contained in this Child/Adolescent Intake Assessment.

Patient Signature_____ Date _____

Parent Signature_____ Date _____

Parent Signature_____ Date _____

Therapist Signature _____ Date _____

We are required to have a safety plan in place, in the event that a Crisis takes place during treatment. Please fill out the following Crisis Safety Plan to the best of your ability.

Thank you.

Client Name _____

MY CRISIS & SAFETY PLAN

_____
Name

Things that really upset me!

1. _____
2. _____
3. _____

People I can ask for help from:

1) _____
2) _____
3) _____

Things that help me to calm down when I'm upset:

1. _____
2. _____
3. _____

Places I can go that will help me to calm down:

1) _____
2) _____
3) _____

If I am unable to feel safe after I try all the things I listed above I will:

1. Call My Therapist(s) or Caseworker:

_____ Phone: _____
Name

_____ Phone: _____
Name

_____ Phone: _____
Name

2. I will or have my parent/guardian call Crisis **717-851-5320**
3. I will or have my parent or guardian call **911**
4. I will have my parent or guardian take me to the nearest hospital
   York Hospital 1001 S. George Street York Pa OR Memorial Hospital 325 S. Belmont Street York

Things I or my parent needs to do to make my home/school safe:

1. _____
2. _____

Medications I can take when I'm in a crisis

Name	How Much	How Often	Prescribed by:

I promise that I will not hurt myself or anyone else but will follow this plan and ask for help during a crisis.

Client Signature: _____ Date_____

Therapist Signature: _____ Date_____

Client Name _____

Mental Status Exam (For Clinician Use Only) Patient _____

Appearance
- ☐ Well Groomed
- ☐ Disheveled
- ☐ Bizarre
- ☐ Body Odor

Mood
- ☐ Normal
- ☐ Depressed
- ☐ Anxious
- ☐ Euphoric
- ☐ Irritable

Attitude
- ☐ Cooperative
- ☐ Uncooperative
- ☐ Suspicious
- ☐ Guarded
- ☐ Belligerent/Hostile

Motor Activity
- ☐ Calm
- ☐ Hyperactive
- ☐ Agitated
- ☐ Tremor/Tics
- ☐ Lethargic

Affect
- ☐ Appropriate
- ☐ Sad
- ☐ Flat
- ☐ Anxious
- ☐ Inappropriate
- ☐ Angry
- ☐ Constricted
- ☐ Labile

Thought Content
- ☐ Normal
- ☐ Morbid
- ☐ Somatic complaints
- ☐ Aggressive
- ☐ Paranoid
- ☐ Phobias
- ☐ Obsessive
- ☐

Hallucinations
- ☐ Auditory
- ☐ Visual
- ☐ Denies

Delusional Beliefs
- ☐ Religious
- ☐ Somatic
- ☐ Persecutory
- ☐ Grandiosity
- ☐ Being controlled
- ☐ Ideas of reference
- ☐ Denies

Bizarre Delusions
- ☐ Thought Broadcasting
- ☐ Thought Insertion
- ☐ Thought Withdrawal
- ☐ Denies

Orientation
- ☐ Person
- ☐ Place
- ☐ Time
- ☐ Responds to name
- ☐ Knows familiar faces or places
- ☐ Knows own daily schedule

Thought Process
- ☐ Intact
- ☐ Tangential
- ☐ Circumstantial
- ☐ Loose Associations
- ☐ Flight of ideas
- ☐ concrete thinking
- ☐ Inability to abstract
- ☐ Follow 1-step directions

Speech
- ☐ Normal
- ☐ Soft
- ☐ Loud
- ☐ Pressured
- ☐ Halting
- ☐ Incoherent
- ☐ Slurred
- ☐ Nonverbal
- ☐ Limited communication skills
- ☐ Uses yes/no only
- ☐ Uses a picture board

Insight
- ☐ Good
- ☐ Fair
- ☐ Poor

Judgment
- ☐ Intact
- ☐ Impaired

Command Hallucinations
- ☐ Harm to self
- ☐ Harm to others
- ☐ Can resist commands
- ☐ Denies

_____ _____

Therapist Signature Date