

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:

PROBLEM BEHAVIORSPlease 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

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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 _____

Client Name _____

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

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***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

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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:

<ul style="list-style-type: none"><input type="checkbox"/> None<input type="checkbox"/> Unusual swelling<input type="checkbox"/> Unusual weight gain If yes, how much? _____<input type="checkbox"/> Unusual weight loss If yes, how much? _____<input type="checkbox"/> High blood pressure<input type="checkbox"/> Infections<input type="checkbox"/> Bleeding<input type="checkbox"/> Unusual vomiting<input type="checkbox"/> Smoking during pregnancy<input type="checkbox"/> Alcohol use<input type="checkbox"/> Use of street drugs	<ul style="list-style-type: none"><input type="checkbox"/> Medications taken during pregnancy (please list names and reason for taking) _____ _____<input type="checkbox"/> Disease or exposure to contagious disease (please explain) _____ _____<input type="checkbox"/> Persistent emotional stress, depression or anxiety (please explain) _____ _____
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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? _____

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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?

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

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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 _____

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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)

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	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:

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

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: _____

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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

<input type="checkbox"/> Talk to family	<input type="checkbox"/> Talk to support group	<input type="checkbox"/> Other _____
<input type="checkbox"/> Talk to friends	<input type="checkbox"/> Resources on internet	<input type="checkbox"/> Other _____
<input type="checkbox"/> Pray	<input type="checkbox"/> Journal	<input type="checkbox"/> Other _____
<input type="checkbox"/> Talk with professional	<input type="checkbox"/> Yoga/Exercise	<input type="checkbox"/> 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.

Crisis and Safety Plan for _____

Name _____

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity): See Coping Technique Handout

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Step 3: People whom I can ask for help and social settings that provide distraction:

- | | |
|----------------|-------------|
| 1. Name _____ | Phone _____ |
| 2. Name _____ | Phone _____ |
| 3. Place _____ | |
| 4. Place _____ | |

Step 4: Professionals or agencies I can contact during a crisis:

- | | |
|-------------------------|-------------|
| 1. Clinician Name _____ | Phone _____ |
|-------------------------|-------------|

(During Office Hours Only: _____) after office hours, please call the following:

*****Crisis Intervention Services Phone number: 717-851-5320

3. Hospital Address: York Hospital, 1001 S. George St, York Pa 17401; Memorial Hospital, 1701 Innovation Drive, York, PA 17408; Hanover Hospital, 300 Highland Ave, Hanover, PA 17331

4. Emergency Services: Dial 911 on phone

Step 6: Making the environment safe:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
|----------|----------|

Step 7: Medications I can take during a crisis (Take as prescribed by medical doctor)

Name	Dosage	Frequency	Prescribed By

I will not hurt myself or anyone else, but rather will abide by this plan and seek help during a crisis.

Patient Signature _____	Date _____
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Therapist Signature _____	Date _____
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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

Orientation

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

Delusional Beliefs

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

Bizarre Delusions

- ☐ Thought Broadcasting
- ☐ Thought Insertion
- ☐ Thought Withdrawal
- ☐ Denies

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

Thought Process

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

Command Hallucinations

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

Therapist Signature

Date