



Okapi Counseling and Family Services, PLLC

CHILD AND ADOLESCENT INTAKE FORM

Name: _____ Date of intake _____
M/F AGE: _____ DOB ___/___/_____
School: _____ Grade: _____
Religious affiliation _____ Ethnicity _____

Family information:

Those living in the home:

NAME /AGE Relationship to child/adolescent

Other significant family or people not living in the home:

Please circle any areas of concerns your child/teen is experiencing:

Aggressive behavior
Fire setting
Relationships
Sleeping
Anger
Health /diet
School
Self-harm
Anxiety

Hygiene
Sexually acting out
Other _____
Bedwetting
Mood
Separation anxiety
Drug use
Potty training
Suicidal thoughts

Briefly explain presenting problem:

On a scale of 1-10 with 1 being the least and 10 being the most how intense are the symptoms your child/teen is currently experiencing?

1 2 3 4 5 6 7 8 9 10

How has the problem affected the following areas:

Daily functioning? _____

School functioning? _____
Family relationships? _____
Social relationships? _____

Treatment

Has the client ever received treatment for any of the documented issues? Y/N
If yes, when? Where? Who was the treating doctor or therapist? _____

How long did treatment last? _____
Was the treatment successful? _____

History of hospitalizations:

Facility/Dates/Outcome

Family history of mental health diagnosis or concerns:

Name Relationship to client

Medical history:

Please briefly explain any significant health concerns (whether past or current) of the client?

Current Physician: _____ Phone number: _____
Date of last physical: _____
Please explain any other Family members significant health issues: (surgeries, diagnosis, Etc.)

Medications:

List any prescribed medicines
Name Prescribed for

Does the client have any history of drug/alcohol use? If yes, please explain: _____

Is there family history of drug/alcohol use? If yes, please explain: _____

Trauma/Abuse History:

Please explain any significant traumas either experienced or witnessed by the client: (this includes physical, emotional and sexual abuse) _____

Other significant life events (separations from parent(s), death in family)

GOALS FOR COUNSELING

1. _____

2. _____

3. _____
