Family Resource Center
Prevent Child Abuse Habersham

ADOLESCENT- CHILD INTAKE/ASSESSMENT FORM

Child/Client:		**Date of Birth:**	
Sibling:		*Date of Birth:*	
Sibling:		*Date of Birth:*	
Sibling:		*Date of Birth:*	
Sibling:		*Date of Birth:*	
Sibling:		*Date of Birth:*	

***1. Parent's Name*:**_____DOB:_____

Address (City, State and Zip):_____

Marital Status:_____Male/Female:_____

Phone: H(____)_____W(____)_____C(____)_____

Emergency contact (name and phone #)_____

***2. Parent's Name*:**_____DOB:_____

Address (City, State and Zip):_____

Marital Status:_____Male/Female:_____

Phone: H( )_____W( )_____C( )_____

Emergency contact (name and phone #) _____

3. Step Parent(s)/Guardian(s):_____DOB: _____

Address (City, State and Zip):_____

Marital Status:_____Male/Female:_____

Phone: H(____)_____W(____)_____C(____)_____

Emergency contact (name and phone #)_____

☐ **Need Court Order Outlining Parental Rights** ⇨ **Use Box Below to Describe Current Custody**

History of Problem

Please describe what concerns you have regarding your child:_____

_____

_____

_____

How long has the problem existed? _____

_____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

_____

_____

_____

What attempts have been made to resolve the difficulties?_____

_____

Please check the symptoms that the child is currently experiencing. Please indicate to which family member you are referring, as well as duration, and severity.

			Severity of symptom *None Mild Moderate Severe* *0 1 2 3*
Symptom	*Name(s)*	*How Long?*	
Sadness or Depression			
Suicidal Thoughts			
Sleep Problems			
Changes in Appetite			
Weight Change			
Inability to Concentrate			
Obsessive thoughts			
Tension and Anxiety			
Panic Attacks			

Symptom	*Name(s)*	*How Long?*	*Severity of symptom* *None Mild Moderate Severe* *0 1 2 3*
Memory Problems			
Compulsive Behaviors			
Feelings of Hostility			
Acts of Violence			
Social Isolation			
Strange Thoughts			
Stomach Aches			
Head Aches			
Bed Wetting			
Phobias			
Other			

Parent Information

Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, law enforcement,etc)?

_____

_____

_____

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)_____

_____

_____

Is ex-spouse (biological parent) aware that you are bring their children to counseling? Yes___No_____

If not, please explain._____

_____

_____

If adopted, does child know of adoption? Yes_____No _____

What age was your child at the time of the adoption?_____

Mother's Name:_____Age: _____Occupation: _____

Employment status:_____Employer's name and address: _____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Current and past psychiatric treatment or counseling:_____

Currently prescribed medications:_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use?_____

History of arrest?_____

Primary Care Physician:_____

Psychiatrist:_____

Father's Name:_____Age:_____Occupation: _____

Employment status:_____Employer's name and address: _____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Current and past psychiatric treatment or counseling:_____

Currently prescribed medications:_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use?_____

History of arrest?_____

Primary Care Physician:_____

Psychiatrist:_____

Step-parent/Guardian:_____Age:_____Occupation: _____

Employment status:_____Employer's name and address: _____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Current and past psychiatric treatment or counseling:_____

Currently prescribed medications:_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use?_____

History of arrest?_____

Primary Care Physician:_____

Psychiatrist:_____

Child Information:

1). Name of Child:_____Age:_____Child lives with:_____

School:_____Grade:_____Teacher: _____

History of psychiatric treatment or counseling:_____

Current or past drug or alcohol use (indicate past or present amount, frequency)_____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Medications currently prescribed:_____

Pediatrician:_____

Psychiatrist:_____

2). Name of Child:_____Age:_____Child lives with:_____

School:_____Grade:_____Teacher: _____

History of psychiatric treatment or counseling:_____

Current or past drug or alcohol use (indicate past or present amount, frequency)_____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Medications currently prescribed:_____

Pediatrician:_____

Psychiatrist:_____

3). Name of Child:_____Age:_____Child lives with:_____

School:_____Grade:_____Teacher: _____

History of psychiatric treatment or counseling:_____

Current or past drug or alcohol use (indicate past or present amount, frequency)_____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Medications currently prescribed:_____

Pediatrician:_____

Psychiatrist:_____