**A New Tomorrow**

**Behavioral Health Services**

**26 Wesmark Ct., Sumter, S.C. 29150**

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**Child & Adolescent Intake**

*The following questionnaire is to be completed by the parent or guardian. This form has been designed to provide necessary information to our providers. As you complete this form, feel free to add any additional information which you think may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request.*

# General Information:

Date:

Sex: Gender Identity (Optional): Sexual Preference (Optional):

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race/Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: Patient’s Social Security Number:

Parent/Guardian:

Home Address:

Street City/State Zip

Home/Primary Phone:

Cell Phone: Mother: Father:

Is it okay to leave messages? \_\_\_yes \_\_\_no

Emergency Contact Name and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to leave messages? \_\_\_\_\_\_\_\_\_\_\_

Email:

School: Grade:

School’s Telephone Number:

Teacher(s):

Does client attend special classes at school? yes \_\_ no

Does client have an IEP, 504, or require extra resource classes at school? \_\_\_\_yes \_\_\_\_no

If yes, explain:

Special accommodations needed for therapy (including technology, literacy needs, translation need):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spiritual / Cultural Factors (Optional):

Please Describe Your Child’s Social Interactions:

# Parents/Guardians and Family Information:

Mother’s Name:

Age:

Occupation: Education Completed:

Father’s Name: Age:

Occupation: Education Completed:

Marital Status (circle one): Married Remarried Divorced Separated Widowed Single Cohabitants

**Siblings:** List IN ORDER BY AGE siblings of client.

Sibling Name Age School Grade Year Conduct\*

How would you say the client gets along with their siblings?

**\***(Please indicate good, fair, or poor conduct)

Great Very Good Good Fair Poor Very Poor

Describe relationship with siblings:

Describe relationship with parents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the occupants in the home, and describe current living situation:

**Please check any that apply (or history of any below)**

\_\_\_\_\_ Discrimination due to Race

\_\_\_\_\_ Discrimination due to Ethnicity

\_\_\_\_\_ Discrimination due to sexual orientation

\_\_\_\_\_ Discrimination due to Gender Identity

\_\_\_\_\_ Discrimination due to Religion

\_\_\_\_\_ Discrimination due to mental or physical disability

\_\_\_\_\_ Food Insecurity

\_\_\_\_\_ Housing Insecurity

\_\_\_\_\_ Lack of transportation/insecurity

\_\_\_\_\_ Lack of employment

\_\_\_\_\_ Lack of childcare/insecurity

**Family History**

Has anyone in the birth family had any of the following psychological disorders?

|  |  |  |
| --- | --- | --- |
| Yes | Condition | Family Member |
|  | General Developmental Delays or Cognitive Delay |  |
|  | Speech or Communication Disorder |  |
|  | Intellectual Disability |  |
|  | Attention-Deficit / Hyperactivity / Impulsivity |  |
|  | Learning Problems / Disabilities |  |
|  | Autism Spectrum / Asperger’s Disorder |  |
|  | Sleep Disorders |  |
|  | Generalized Anxiety (across many situations) |  |
|  | Social Anxiety |  |
|  | Obsessive-Compulsive Disorder  Phobias |  |
|  | Depression |  |
|  | Manic-Depression / Bipolar Disorder Suicide Attempts / Suicide |  |
|  | Schizophrenia or other psychosis |  |
|  | Alcohol Abuse |  |
|  | Drug (Including Nicotine and Vapes) Abuse |  |
|  | Seizures or other neurological disorder |  |
|  | Genetic Disorder (e.g., Down Syndrome, Fragile X) |  |
|  | Other: | |

# Medical History

Name of child’s Primary Care Physician:

Physician’s Address:

Physician’s Phone:

List any other physician or health professional your child sees on a regular basis:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your child last seen by a physician?

Is your child up to date on all immunizations? \_\_\_\_ Yes \_\_\_\_\_ No

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical or physical health conditions your child has had and the impact on the client:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was it a normal pregnancy including prenatal care and delivery with the child? Please explain any complications or any prenatal exposure to substances such as alcohol, illegal drugs or nicotine.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any motor developmental, speech and language, self regulation, issues in the home, social/emotion skills or feeding difficulties that may be impacting your child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any issues your child may have with speech, hearing or visual functioning:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications your child is currently taking. Also, list previous medications and dates if taken for an extended period of time. Please indicate the effectiveness of all medications. Use back of page if needed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# List any medications your child is allergic to or has an adverse reaction towards:

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# List any holistic medical practices you child engages in (chiropractic, yoga, messages ect.):

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Patient Psychiatric History

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was the presenting issues?

Have there been any developmental concerns for your child? Have they ever had a developmental assessment completed? If so, by whom, when, and what was the concern?

# Behavior Management / Discipline

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed: (circle the appropriate number)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Very | Unlikely |  |  |  | Very Likely |
| Let situation go | 1 | 2 | 3 | 4 | 5 |
| Time out | 1 | 2 | 3 | 4 | 5 |
| Send to room | 1 | 2 | 3 | 4 | 5 |
| Take away a privilege (ex., no TV) | 1 | 2 | 3 | 4 | 5 |
| Take away something material (ex., no toy) | 1 | 2 | 3 | 4 | 5 |
| Assign an additional chore | 1 | 2 | 3 | 4 | 5 |
| Ground child | 1 | 2 | 3 | 4 | 5 |
| Reason with child/problem solve/negotiate | 1 | 2 | 3 | 4 | 5 |
| Yell at child | 1 | 2 | 3 | 4 | 5 |
| Physical punishment | 1 | 2 | 3 | 4 | 5 |
| List anything else you may do: |  |  |  |  |  |
|  | 1 | 2 | 3 | 4 | 5 |
|  | 1 | 2 | 3 | 4 | 5 |

# History of Trauma:

# Please describe any trauma that is/was experienced or witnessed including but not limited to Abuse, Neglect, Violence or Sexual Assault:

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the five things that you would like your child to do more of and less of in order of priority to you. For example, instead of saying, “I want my child to be more responsible,” translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Would like Child to do More Often Would like Child to do Less Often



# Current Symptoms:

Please indicate if your child is experiencing any of the following:

* + School attention/concentration problems
  + Grades dropping or consistently low
  + Hyperactive, difficulty being still
  + Impulsive, doesn’t think before acting
  + Sadness or Depression
  + Generalized Anxiety (across many situations)
  + Specific fears/phobias (list):
  + Social Anxiety
  + Obsessive-Compulsive/Rigid behavior patterns
  + Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
  + Isolated socially from peers
  + Problems making or keeping friends
  + Problems with eating
  + Problems with falling asleep
  + Problems sleeping through the night (middle of the night or early morning waking)
  + Trouble waking up
  + Fatigue/tiredness during the day
  + Nightmares
  + Noncompliant, purposely does not obey (not due to language or cognitive deficits)
  + Oppositional, defiant behavior
  + Problems controlling temper
  + Tantrums/ “meltdowns”
  + Problems with authority (breaking rules or laws)
  + Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)
  + Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)
  + Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)
  + Suicidal thoughts or actions
  + Intent or attempt to harm others
  + Wetting accidents (indicate day or night wetting):
  + Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)
  + History of abuse (emotional, physical, sexual)
  + Alcohol use
    - if yes, current use? \_\_\_\_\_\_
    - history of use? \_\_\_\_\_\_
    - how often per week? \_\_\_\_
  + Nicotine use (Vapes and E-cigarettes included)
    - if yes, current use? \_\_\_\_\_\_
    - history of use? \_\_\_\_\_\_
    - how often per week? \_\_\_\_
  + Illegal Drug use
    - if yes, current use? \_\_\_\_\_\_
    - history of use? \_\_\_\_\_\_
    - how often per week? \_\_\_\_
  + Vocal or motor tics (e.g., grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)
  + Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)
  + Stress from conflict between parents
  + Stress due to family financial problems
  + Legal situation (anyone in family)

Other behavioral problems:

Any other risk taking behaviors:

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Legal History

Have you ever filed or been involved in any litigation? Please include any family court or DSS cases. Please explain.

Is there anything else we should know about your child that was not covered by this form including significant life events?

# Insurance:

Primary Insurance: ID Number:

Name of Insured: Insured’s Date of Birth:

Insured Address: Phone:

Secondary Insurance: ID Number:

Name of Insured: Insured’s Date of Birth:

Insured Address: Phone:

# Responsible Party:

Name: Relationship: Address: Primary Phone: Alternate Phone:

**I authorize this provider to release any information, including diagnosis, treatment plans / records to third party payers and / or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the provider or medical benefits that are, otherwise, payable to me. I understand that my medical insurance may pay less than the actual bill for service or may not cover certain treatment.**

**I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this medical office. I accept responsibility and understand that I am responsible for the charges and fees that are due at the time service is provided, unless I make arrangements in advance.**

Signature: Date:

**I, , hereby declare that I am the primary custodial parent, or legal guardian of the client, , as certifies by Birth Certificate or Family Court/Guardianship documents. If there are other parents or legal guardians involved please list them below.**



**Name relationship to client phone number**



**Name relationship to client phone number**