



HIGH PLAINS PSYCHOLOGICAL ASSESSMENT CENTER,
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CHILD AND ADOLESCENT INTAKE FORM

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Client's (child) Name: _____ Today's Date: _____

Date of Birth: _____ / _____ / _____ Child's age _____

Child's School: _____ Grade: _____

Name of person completing this form: _____

Relationship to client: _____

Are you the legal guardian of the child? Yes _____ No _____

If no, who is the child's legal guardian? _____

Address: _____

Home phone: _____

May I leave a message? Yes No

Mother's Cell phone: _____

May I leave a message? Yes No

Father's Cell phone: _____

May I leave a message? Yes No

Mother's Work phone: _____

May I leave a message? Yes No

Father's Work phone: _____

May I leave a message? Yes No

Email: _____

May I email you? Yes No

May I send you text message appointment reminders? Yes No Phone number for texts _____

Who referred you to High Plains? Please provide agency/professional's name and contact information:

Adoption History

Was the child adopted? _____

If yes, what age was he/she adopted? _____ Is he/she aware of their adoption? _____

How many home placements/homes has the child had in his/her lifetime? (Please describe in terms of type of placement, age at placement, reason for change in living arrangement, etc.) _____

Does the child have contact with his/her biological mother and/or father? _____

Pregnancy and Birth History

This child was the birth mother's _____ (write number) pregnancy.

List any complications during the pregnancy: _____

List any prescription medications, alcohol, nicotine or drugs taken during pregnancy: _____

The child was delivered via: C-Section _____ Vaginal Delivery _____

Was the child considered full term? Yes _____ No _____

How many weeks gestational age was the child when he/she was delivered? _____

Birth weight _____

List any delivery complications: _____

How long was the child in the hospital after delivery? _____

Interventions required for the child after birth (phototherapy, oxygen, etc.): _____

Did the child's mother experience depression or anxiety in the first two years of the child's life? _____

Early Developmental Milestones

Please indicate the approximate age at which the child met the following milestones:

First single words _____

First 2-3 word phrases _____

Sat unassisted _____

Crawled _____

Walked _____

Pretend play _____

Toilet trained (day) _____

Toilet trained (night) _____

HEALTH INFORMATION

Does your child currently have any medical problems? _____

Has your child ever been treated for any of the following? If so please circle and describe:
Head injury, strokes, seizures, fainting, loss of consciousness, neurologic conditions (Multiple sclerosis, Parkinson's), cancer, headaches, diabetes/kidney, allergies, chronic fatigue, high fevers, surgeries, any other conditions:

Please list current prescription medications with dosage (psychiatric and general health):

Please list any previous psychiatric medications (with dosage and dates): _____

Who is your child's primary care physician? _____

Who is your child's psychiatrist (if applicable)? _____

When was your child's last complete physical exam (month/year)? _____

Personal History

Where was your child born? _____

How many times has your child moved? _____

List all people who currently live with the child? _____

Parents are: Married ____ Divorced ____ Separated ____ Never Married ____ Other _____

Type of Legal Custody: Joint ____ Sole ____ Other _____

Type of Physical Custody: Joint ____ Sole ____ Other _____

*Please provide current separation agreement or court order to verify legal custody.

Do you have any pending custody matters? Yes ____ No ____ Please describe: _____

Has Child Protective Services ever been involved or has there been an abuse report filed against any of the child's care takers? Yes ____ No ____

If yes, please explain (When, what, who was involved, what state, what was the finding): _____

Siblings

Please list all of your child's brothers and sisters.

First name	Full, Half, Step, Adoptive	Current Age	Male/Female	Describe your child's relationship with this individual in a few words

What are the main reasons you're seeking an evaluation/therapy? (Please include how long you have noticed these symptoms or problems): _____

What do you hope to gain from this evaluation/therapy? _____

SYMPTOMS:

How much are each of the symptoms below a concern for your child?

	Not at all	A little	Somewhat	Considerably	Terribly
	1	2	3	4	5
Academic/Learning Problems	1	2	3	4	5
Behavior Difficulties	1	2	3	4	5
Problems with Social Relationships	1	2	3	4	5
Social Withdrawal	1	2	3	4	5
Restricted Interests	1	2	3	4	5
Anxiety	1	2	3	4	5
Fear of Certain Objects/Situations	1	2	3	4	5
Repetitive Behaviors or Mental Acts	1	2	3	4	5
Avoiding Certain Things/Places	1	2	3	4	5
Panic Attacks	1	2	3	4	5
Intrusive Memories	1	2	3	4	5
Irritability	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Changes in Eating/Appetite	1	2	3	4	5
Depression	1	2	3	4	5
Low Self-Esteem	1	2	3	4	5
Self-harm/Suicidal Thoughts	1	2	3	4	5
Inappropriate Expression of Anger	1	2	3	4	5
Difficulty Meeting Expectations	1	2	3	4	5
Difficulty Problem-solving	1	2	3	4	5
Memory Problems	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Legal Problems	1	2	3	4	5
Family Conflicts	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Please describe any other symptoms your child has experienced (not listed above).

Has your child experienced any unusually severe stresses during the last year? Yes No

If yes, please describe: _____

What do you consider to be your child's strengths? _____

What do you consider to be areas of needed growth for your child? _____

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did your child see and for what reason? About how many meetings did he/she have? Was the experience helpful or not? How so? _____

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

Has your child attempted suicide? Yes _____ No _____

Has your child engaged in self-harm behaviors? Yes _____ No _____

If yes, please describe:

To the best of your knowledge, please indicate for each substance listed below

Substance	Ever Used?	Age at 1 st Use	Time Since Last Use	Approx. Use in last 30 days
Alcohol				
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				
Other Drugs				

FAMILY MENTAL HEALTH HISTORY

In the section below identify any members of your child's family and extended family who have a history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided.

	Please circle		List Family Member(s)
Anxiety (general)	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Depression	Yes	No	_____
Suicide Attempts	Yes	No	_____
Bipolar/Manic Depressive	Yes	No	_____
Schizophrenia	Yes	No	_____
Substance Abuse	Yes	No	_____
Domestic Violence	Yes	No	_____
Eating Disorders	Yes	No	_____
Attention-Deficit/Hyperactivity Disorder	Yes	No	_____
Autism Spectrum Disorder	Yes	No	_____
Learning Difficulties	Yes	No	_____
Psychiatric Hospitalizations	Yes	No	_____

Educational History

Does your child receive any special accommodations in school (Individualized Education Program, 504 Plan, informal supports)?

Has your child ever repeated a grade? _____

What have teachers and other school professionals told you about your child? _____

What subject(s) does your child excel in? _____

What subject(s) does your child struggle with? _____

Social Relationships/Interests/Activities

Please describe your child's social relationships. _____

What are some of your child's interests & activities? _____

Is there any other information you would like us to know about your child? _____
