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Child-Adolescent Intake

The following information is designed to support your child's treatment. The information provided in these forms will be handled confidentially.

Child's Full Name:	Nickname:
Birth Date:	Today's Date
Child's Address:	Phone:
Parent(s) names or primary guardian:	Parent(s) contact numbers: Home: Cell: Work
In case of emergency, who may I contact on your behalf?	Name:
Phone number:	Relationship:

Education History

What school does your child attend:	Teacher's Name:
Current Grade:	Has your child ever repeated a grade? YES/ NO If so which one(s)_____
Favorite Subject:	Least Favorite Subject:
Does child receive special education service? YES / NO	Does child receive tutoring? YES/ NO
Is your child in a gifted/talented/honors program? YES/ NO	Does child like school? YES/ NO
Has you child experienced any of the following at school? (please circle all that apply) Fighting, suspension, lack of friends, gang influence, learning disabilities, incomplete homework, dug/alcohol, poor attendance, behavior problems, detention ,poor grades	
Has your child been the victim of bullying or bullied other children? YES/ NO. If yes, please describe	
Please, use the space to provide any other additional information regarding you child's education or developmental history that you find significant:	

Medical History

Pediatrician's Name:	Phone:
Is child under the care of another medical specialist? YES/NO. If yes, type of specialist _____	Phone:

Please list any chronic illness, disabilities, medical conditions that your child has been diagnosed with:

Illness/Disability	Dates

List all medications that your child is currently taking:

Medication	Dosage	Treating

Therapy / Psychiatric Experience

Is your child <i>currently</i> seeing another therapist? YES / NO			
If yes, who are you seeing?			
Has your child ever been in therapy in the past YES/ NO			
If yes, please fill out the following on your previous counseling experience(s)			
Therapist	Location	Dates	Reason
Has your child ever had a psychiatric hospitalization? YES/ NO			
If yes describe briefly and indicate dates and circumstances			
Is your child under the care of a psychiatrist: YES/ NO		If yes, Psychiatrist name:	
Phone:		Address:	

Other History

Has your child ever experienced any type of abuse (physical, sexual, or emotional)? YES/ NO
If yes, please describe:

Has your child ever made statement of wanting to hurt him/herself or seriously hurt someone else? YES/ NO
Has he/she purposely hurt himself or another? YES/ NO
If yes, to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? YES/ NO.
If yes, please explain:

Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets him/her in trouble? YES/NO. If yes, please describe:

Are there any behaviors that your child fails to do as often as you would like or when you would like?

Please list positive strengths of your child: (What do you like about your child? What do others like about your child?)

How would you describe your child's self-esteem?

Briefly describe your reason(s) for seeking help at this time?

What goals do you wish to accomplish during the therapy process as a parent?

What goals does your child wish to accomplish during the therapy process? (can be different than parent's response)

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Family History

Mother's Name Occupation:	Father's Name: Occupation:
Step-Mother?	Step Father?

Who does your child currently live with?

Names	Age	Relationship to child	Grade/Job

Who are your child's significant others NOT living with your child?

Names	Age	Relationship to child	Grade/Job

Are child's parents'? **Married** **Separated** **Divorced** **Widowed (please circle one)**

If parents divorced/separated please list dates:

Who in the family is your child closest too?

What are some of the strengths of your family?

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? YES / NO
If yes please describe:

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Does anyone in the child's family been diagnosed with a chronic/mental illness? YES/ NO. If yes, please describe:

Is there anything else that you think would be important for me to know about your child, you, or your family?

Who referred you?