Lacamas Counseling & Psychiatry
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LACAMAS COUNSELING & PSYCHIATRY

INTAKE INFORMATION - CHILD

CONTACT INFORMATION & DEMOGRAPHICS

Full name: ____ **Date:**________________

Address: ____

City: __________________________ **State:** __________ **Zip:** ___________

Email address: ____ **Phone:** _____________________

Check mark approved communication: □Voicemail □Text □Email

Parent/Legal Guardian: ____

Email address: ____ **Phone:** _____________________

Check mark approved communication: □Voicemail □Text □Email

Parent/Legal Guardian: ____

Email address: ____ **Phone:** _____________________

Check mark approved communication: □Voicemail □Text □Email

Is there a parenting plan (if so, please provide a copy)? □YES □NO

Emergency Contact Name & Phone: ____

DOB: ___________ **Age**: _______ **Sex:** □**Male** □**Female** □______________

Gender Identity: _____________________ **Preferred Pronouns:** _________________________

Race/Ethnicity: ____

Occupation: ____

Spiritual/Religious Beliefs: ____

Referred by: ____

Please describe any problem behaviors or areas of concern

____

____

____

Do the problems occur more at home and/or school?

____

____

What changes/patterns have you noticed in your child's play?

____

____

Please state the expectations/goals that you have for your child for counseling

____

____

What skills, tools, or approaches are helpful when working with your child?

____

____

What are your child’s strengths?

____

____

Were there any complications or high stress during the pregnancy or birth?

____

____

Has the child experienced any trauma, abuse, or neglect?

____

____

What is the family background and marital status?

____

____

How does your child get along with other children?

____

____

How does your child get along with other adults?

____

____

How does your child get along with family members?

____

____

SCHOOL INFORMATION

School Name ________________________________

Does your child have an Individualized Education Plan (IEP) or any school accommodations?

____

____

Has your child been suspended or expelled?

____

____

Has your child experienced bullying?

____

____

MEDICAL PROVIDERS

Primary Care Physician Name ____________________
Phone Number ______________________________
Clinic Name ________________________________
Date of last Appointment ________________________

List any pertinent mental health diagnosis, medical conditions, health problems, and/or past hospitalizations

____

____

List any medications your child is taking and for what reason

____

____

PREVIOUS MENTAL HEALTH PROVIDERS

Name/Clinic Name ___________________________
Phone Number ______________________________
Date of last Appointment ________________________

Please describe the goals and outcomes with this provider

____

____

OTHER PROVIDERS

Name/Clinic Name ___________________________________
Phone Number _______________________________________
Date of last Appointment _______________________________

Please describe the goals and outcomes with this provider

____

____

OTHER PROVIDERS

Name/Clinic Name ___________________________________
Phone Number _______________________________________
Date of last Appointment _______________________________

Please describe the goals and outcomes with this provider

____

____

Please list any other information that may be helpful while assessing and/or conducting therapy with your child.

____

____

____

____

What else would you like me to know:

____

____

____

____

Check any of the following symptoms that have impacted your child in the last six months

Depressed Mood	Decreased appetite	Compulsive Behaviors
Tiredness/Fatigue	Irregular sleeping	Obsessions
Low energy	Anxiety	Hear/see things others do not
Tearfulness	Panic	Paranoia/Suspicion
Hopelessness	Fear	Reckless Behaviors
Apathy/Lack of care	Social anxiety	Exposure to traumatic event
Loss of interest/pleasure	Panic attacks	Flashbacks (while awake)
Low self-worth	Thoughts of harming others	Nightmares
Low motivation	Suicidal thoughts	Avoid trauma reminders
Isolation from others	Self-harm	Easy startle reflex
Difficulty concentrating	Guilt/Shame	Irritability/Anger
Racing thoughts	Inconsistent mood changes	Frequent anger outbursts
Lack of confidence	Excessive Energy	Other symptoms _________
Increased appetite	Impulsivity	

What stressors/changes have recently impacted the child?

Parents	Alcohol/Drugs	Finances
Siblings	Legal Matters	Sexual abuse/rape
Extended Family	Food/Diet	Bullying
Friends & Social Life	Body Image	Physical abuse
School	Recent Move	Gender Identity & Sexuality
Sports	Medical/Health	Chaotic Life
Work	Grief/Loss/Death	Other __________________

How are these symptoms and stressors affecting your child's every day life?

Personally ____
Family ____
Friendships ____
Social life ____
Work/School ____
Every day tasks ____