Sheltered Cove Counseling Center
6488 Spring St., Suite 102, Douglasville, GA 30134
Ph: 770-949-1595 Fax: 770-489-7521

Child/Adolescent Intake Form

(This form is completely confidential)

Today's Date: ____________________

Client's Name: ______________________________ Client Date of Birth: ________________ Age: ________________

Guardianship of Child/Adolescent

Parent/Legal Guardian's Name (Primary): ____

Please select custody status of child:

Other custody arrangement. Please describe: ____

Does the Primary parent/guardian have both physical and legal custody? Yes No

If no, please describe: ____

Primary Home Address: ____

Home Phone: ______________________________ Cell Phone: ______________________________

Email Address: ____

Parent/Legal Guardian's Name (Secondary/Joint Custody) : ____

Secondary/Joint Home Address: ____

Home Phone: ______________________________ Cell Phone: ______________________________

Email Address: ____

Does the Secondary parent/guardian have both physical and legal custody? Yes No

If no, please describe: ____

Referral/Emergency Contact Information

Referred By: ____

Primary Physician Name: ______________________________ Ph: ______________________________

Person to notify in case of an emergency: ______________________________ Ph: ______________________________
[SCCC staff will only contact this person if we believe it is a life or death emergency.]

I give permission to SCCC staff to call my emergency contact: ____
Primary Guardian Signature

Insurance Information (If no insurance, select Self-Pay)

Primary Ins. Co: ______________________________ ID #: ____________________ Grp #: __________________

Secondary Ins. Co: ____________________________ ID #: ____________________ Grp #: __________________

EAP Provider Name: ___________________________ Auth#__________________ # of Sessions Authorized: _____

Policy Holder name: _______________________________________ Policyholder DOB: _____________________

Policy holder address: _____________________________________ Policyholder SS #: _____________________

Primary Parent/Guardian Employment Information

Employment Status: _____ Full Time _____ Part-Time _____ Self-Employed _____ Student _____ Homemaker _____ Retired

Name of Employer: __________________________ Number of months/years employed: ____________

Type of Work: _____________________________ Stress Level on Scale of 1-10: ________________

Secondary Parent/Guardian Employment Information

Employment Status: _____ Full Time _____ Part-Time _____ Self-Employed _____ Student _____ Homemaker _____ Retired

Name of Employer: __________________________ Number of months/years employed: ____________

Type of Work: _____________________________ Stress Level on Scale of 1-10: ________________

Presenting Concern(s)

Please describe your child's presenting concern(s):

Please describe any symptoms your child is experiencing (panic attacks, lack of focus/concentration, mood, etc):

Please list 2-3 goals for therapy. 1) ____

2)____

3)____

Self-Identification of child (if known)

Gender: _____________ Preferred Pronoun: _____________ Native Language: ______________________

Ethnicity/Cultural Identification: ________________________ Country of Birth: ______________________________

Sexual Orientation: __________________________ Religious/Spiritual Affiliation: __________________________

Education Information

Please select your child's current school setting:

Name of Current School: ______________________ Grade Level: ____________

Please describe any special education needs/learning challenges for your child?

Please select if your child has an ________ IEP __________ 504 Plan.

Any school concerns/stress? ____

Has your child changed schools? ____

Mental/Behavioral Health History

Please share any previous/current Mental Health Diagnosis:

Please describe any current or historic suicidal thoughts or attempts.

Please describe any current or historic self-harm behaviors (i.e. cutting).

Please describe any current or historic homicidal thoughts or attempts.

What are your child's current coping mechanisms?

Please describe your parenting style and method of discipline at home.

Please complete the following treatment history:

Psychiatrist: ______________________________ Dates of Service:________________

Individual Therapy: ______________________________ Dates of Service:________________

Family Therapy: ______________________________ Dates of Service: ________________

Partial Hospitalization (PHP): ______________________ Dates of Service:________________

Intensive Family Intervention (IFI): ___________________ Dates of Service: ________________

Inpatient Hospitalization: ______________________ Dates of Service: ________________

Support Group(s): ______________________________ Dates of Service: ________________

Other: ______________________________ Dates of Service: ________________

Trauma Background

The following section asks about events your child may have experienced in life. Has your child personally experienced or have they ever witnessed the following situations? There are many difficult experiences we can have in childhood. We can personally experience them and/or witness others we care for have them.

Please mark "CHILD" for the following events if your child has experienced them.
Please mark "OTHER" if they happened to someone your child cared for.
Mark "BOTH" if the experience happed to both your child and someone they care for.

DURING CHILDHOOD…

________ Physical Abuse ________ Sexual Abuse/Molestation ________ Rape ________ Verbal Abuse/Bullying

________ Neglect ________ Domestic Violence ________ Absent Parent ________ School Violence

________ Chronic Illness ________ Parents Fighting ________Divorce ________ Burns or Serious Injury

________ Medical Trauma ________ Death of a loved one ________ Accident (car/other) ________ Natural Disaster

________ Community Violence ________ Other ____

In the space provided please write anything you would like us to understand about what happened.

Social & Family History

Who does your child currently live with?

Any concerns with home environment?

Please describe your child's current support system.

Please describe any verbally or physically abusive relationships that impacted the child.

How would you describe the child's relationship with bio-mother?

How would you describe the child's relationship with bio-father?

Parent's marital status: ________ Never Married ________ Married ________ Separated ________ Divorced ________ Other

If the child's parents are no longer together, how old was the child when they separated? ______________

If parents are separated/divorced, how did this impact the child?

Please describe any other primary care givers who significantly impacted the child?

How many siblings does the child have (list names and ages)?

How would you describe your child's relationship with siblings?

Please share any FAMILY HISTORY of Mental Health Illnesses, Diagnosis, Treatment, etc.

Please share any FAMILY HISTORY of Alcohol or Drug Abuse/Addiction.

Legal History

Please share any legal issues that impacted the child. (i.e. custody hearings, parent being in jail/prison, etc)

Physical/Medical History

Please share any significant **CURRENT** medical problems (i.e. diabetes), symptoms, or illnesses for your child:

Condition #1: ______________________________ When was the child diagnosed? __________

Condition #2: ______________________________ When was the child diagnosed? __________

Condition #3: ______________________________ When was the child diagnosed? __________

Please share any significant **HISTORY** of medical problems (i.e. diabetes), symptoms, or illnesses for your child:

Condition #1: ______________________________ When was the child diagnosed? __________

Condition #2: ______________________________ When was the child diagnosed? __________

Condition #3: ______________________________ When was the child diagnosed? __________

Please list your current medications (including over the counter meds and supplements/vitamins):

#1) __________ Dose __________ Purpose ______________ Prescribing Dr. __________

#2) __________ Dose __________ Purpose ______________ Prescribing Dr. __________

#3) __________ Dose __________ Purpose ______________ Prescribing Dr. __________

Alcohol and Other Drug History

Has your child been exposed to or tried any drugs or alcohol?

Strengths & Challenges

What are your child's current challenges?

What are your child's current personality strengths?

What are your child's current skills and abilities?

For the following list of symptoms, please mark "C" for **Current Symptom** and "P" for a **Past Symptom** or "B" for **Both** regarding your child.

______ Anxiety
______ Depression
______ Mood Changes
______ Anger/Temper
______ Panic
______ Fears
______ Irritability
______ Concentration
______ Headaches
______ Loss of Memory
______ Excessive Worry
______ Feeling Manic
______ Trusting others
______ Communication
______ Drugs
______ Alcohol
______ Caffeine
______ Frequent Vomiting
______ Eating Problems
______ Severe weight gain
______ Severe weight loss
______ Blackouts
______ People in general
______ Parents

______ Children
______ Marriage/Partner
______ Friend(s)
______ Co-Worker(s)
______ Employer
______ Finances
______ Legal Problems
______ Sexual Concerns
______ Child Abuse
______ Sexual Abuse
______ Domestic Violence
______ Thoughts of hurting others
______ Hurting Self
______ Suicidal Thoughts
______ Sleeping too much
______ Sleeping too little
______ Getting to sleep
______ Waking too early
______ Nightmares
______ Head Injury
______ Nausea
______ Abdominal Distress

______ Fainting
______ Dizziness
______ Diarrhea
______ Shortness of breath
______ Chest Pain
______ Lump in the Throat
______ Sweating
______ Heart Palpitations
______ Muscle Tension
______ Pain in joints
______ Allergies
______ Often makes careless mistakes
______ Fidget frequently
______ Speak without thinking
______ Waiting your turn
______ Completing tasks
______ Paying Attention
______ Easily distracted by noises
______ Hyperactivity
______ Chills or Hot Flashes

Please add any additional information you believe is relevant to your presenting issue for counseling.

Thank you for taking the time to share your background with us so that we may provide the best treatment for you!
We look forward to meeting you soon.