## Counseling Center

### **Child-Adolescent Intake**

Please provide the following information about your child:

C1. 11.12 - E11 M	your chiu:
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:
	,, 5220
In case of emergency, who may I contact on	Name:
your behalf?	T (diffe)
Jose Commit.	
Phone number:	Relationship:
I none 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 your child receive special education	Does your child receive tutoring?	
service?		
	YES/ NO	
YES /NO		
Is your child in a gifted/talented/honors	Does your child like school?	
program?		
YES/ NO	YES/ NO	
Has your child experienced any of the following	ng at school? (please circle all that apply)	

Has your child experienced any of the following at school? (please circle all that apply)

Fighting, suspension, lack of friends, gang influence, learning disabilities, incomplete homework, drug/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:

#### **HIGH LEVEL**

Counseling Center

407-668-6025

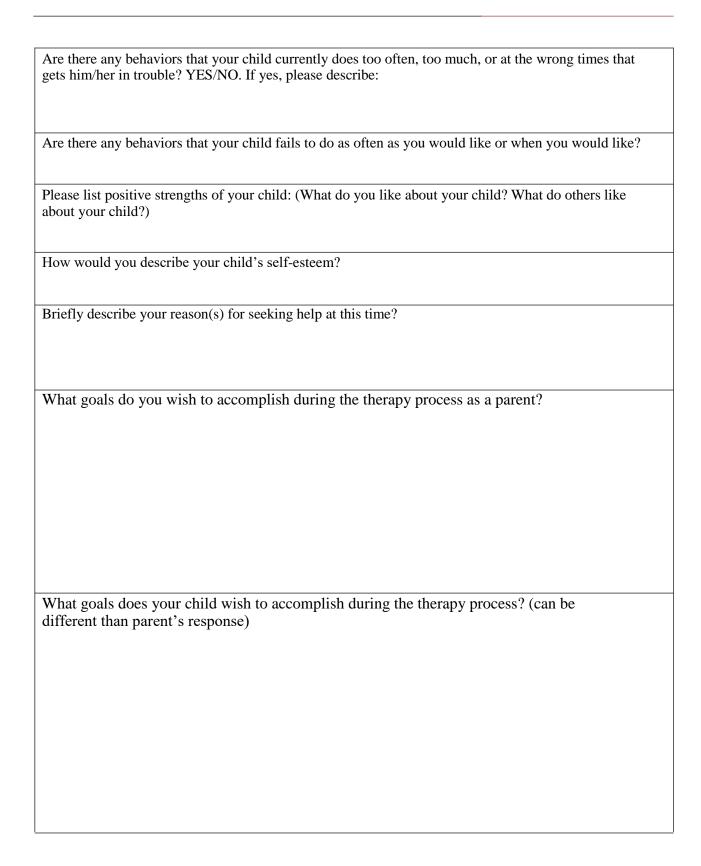
Please, use the space to pro	ovide any other add	itional informati	on regarding your	
child's education or develo				
	Medic	cal History		
Pediatrician's Name:		Phone:		
Is child under the care of a	nother medical	Phone:		
specialist? YES/NO If yes, type of specialist				
ir yes, type or specialist				
Please list any chronic ill	ness, disabilities, n	nedical conditio	ns that your child has been	
diagnosed with:		1_		
Illness/Disability:		Dates:		
List all modications the	at vour child is o	urrantly takin	α·	
List all medications the Medication:	Dosage:	urrently taking	Treating:	
THE CONTRACTOR OF THE CONTRACT	Dobuger		Treating.	

#### **HIGH LEVEL** Counseling Center

### Therapy / Psychiatric Experience

Is your child currently s	seeing another therapist?	YES / NO	
If yes, who are you seei	ng?		
Has your child ever bee	n in therapy in the past	YES/ NO	
If yes, please fill out the	e following on your prev	ious counseling experien	nce(s)
Therapist	Location Dates Reason		
	a psychiatric hospitaliza		
, ,	nd indicate dates and cir	cumstances	
Is your child under the of YES/ NO	Is your child under the care of a psychiatrist: YES/NO  If yes, Psychiatrist name:		
Phone:		Address:	
	<u>Other</u>	<u>History</u>	
Has your child ever exper NO If yes, please describe	rienced any type of abuse (je:	physical, sexual, or emotion	onal)? YES/
	statement of wanting to hit himself or another? YES/		
Has your child ever exper from a parent or other car If yes, please explain:	rienced any serious emotion etaker)? YES/ NO.	nal losses (such as a death	of or physical separation

#### **HIGH LEVEL**



# Counseling Center

### **Family History**

Mother's Name		Father's Name: Occupation:	
Occupation:		Geeupation.	
Step-Mother?		Step Father?	
Who does your child cu	irrently live with?		
Names	Age	Relationship to child	Grade/Job
Who are your child's si	gnificant others NOT livi	ing with your child?	
Names	Age	Relationship to child	Grade/Job
Are child's parents'?  If parents divorced/sepa	Married Separated arated please list dates:	Divorced Widowed (ple	ease circle one)
Who in the family is yo	ur child closest too?		
What are some of the st	rengths of your family?		
Does anyone in the chil NO If yes, please descri	d's family been diagnose be:	d with a mental illness?	YES/

#### **HIGH LEVEL**

407-668-6025

Is there anything else that you think would be important for me to know about your child, you, or your family?
or your faining:
How did you hear about our services? Internet search? Website?