



Associates in Human Development Counseling, LLC

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Intake for Children and Adolescents

May be completed by parent

Name of Child/Adolescent: _____ Date of Birth: _____
School: _____ Grade Level: _____ Age: _____
Child's Address: _____
City, State, Zip: _____
Number of Years at Current Residence: _____

Parent Contact Information

Parent name(s): _____
Telephone (Home): _____ May we leave a message? Yes No
Telephone (Work): _____ May we leave a message? Yes No
Telephone (Cell): _____ May we leave a message? Yes No
E-mail Address: _____ May we contact you via e-mail? _____
Other: _____

Do you have any further requests regarding the manner in which we may contact you?

Referral Information

Who referred you to our practice? _____

May we contact this person to confirm your visit? Yes No

Has there been any law enforcement/court involvement regarding this referral? Yes No

Has there been any police involvement with your family during the past 5 years, other than traffic violations? Yes No

If you answered yes to either of the questions above, please explain: _____

Child's Name: _____

Date: _____



Family Background

Name and ages of immediate family (including parents, step parent, siblings, & step siblings)

Name	Age	Relationship	Resides with Child/Adolescent	
			Yes	No
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Education Information

Current Grade Level or Highest Grade Completed: _____

Number of years in current school or school district: _____

Is child/adolescent currently attending school? _____ Yes _____ No

If "No," explain: _____

Is child/adolescent enrolled in any special education classes? _____ Yes _____ No

If "Yes," are these classes due to a:

_____ Learning Disorder _____ Behavioral Disorder _____ Emotional Disorder _____ Other

Has child/adolescent ever been retained (not advanced to the next grade)? _____ Yes _____ No

Has child/adolescent ever been _____ Suspended or _____ Expelled from a school?

If child/adolescent has been suspended or expelled, please explain:

Optional- contact will only be made with a valid release of information

School contact person: _____ Title: _____ Phone: _____

Child's Name: _____

Date: _____



Presenting Concern

Why are you seeking help for your child/adolescent at this time?

What has been your experience with prior counseling for your child/adolescent?

Has your child/adolescent ever been diagnosed with a psychological disorder? Yes No
If "Yes," please give diagnosis and date of diagnosis: _____

Is your child/adolescent taking or has he/she ever taken any psychotropic medication?
 Yes No

If yes:

Name of Medication	Dose	Current	Past
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child/adolescent experienced any health issues you would like us to be aware of?

Does your child have any allergies?

Child's Name: _____

Date: _____



Has your child/adolescent ever experienced a head injury? _____ Yes _____ No

To the best of your knowledge, has your child/adolescent ever used: ___ Drugs ___ Alcohol?

Has your child/adolescent ever been hospitalized for physical health reasons? ___ Yes ___ No

If "Yes," please

explain: _____

Has your child/adolescent ever been hospitalized for psychiatric or behavioral reasons?

_____ Yes _____ No

If "Yes," please explain:

Expected Outcomes

How would you hope our services can be helpful to your child/adolescent or yourself?

Do you plan to submit your receipts for insurance reimbursement? ___ Yes ___ No

Do we have your permission to release information to your insurance company should they contact us? _____ Yes _____ No

Safety Information

Please complete if applicable

Are there any circumstances regarding any parent or significant party that you would like us to be aware of?

Is your child/adolescent named as a protected person on an order of protection? ___ Yes ___ No

If "yes," please explain: _____

Signature of Person Completing Form

Date

Child's Name: _____

Date: _____