Doreen A. Zaborac & Associates, Inc.

Zaborac Counseling Group

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Intake Form (Child/Adolescent)

Client Name:________________________________ D.O.B.___________ Age: _________

What made you decide to seek counseling? ____

____

____

Mental Health History:

Has the client previously received mental health services (counselors, psychiatrist, etc.)? ▢ YES ▢ NO

If yes, who did the client see and for how long?____

____

Have you been prescribed medication for a mental health condition? ▢ Yes ▢ No

Are you currently taking medication for a mental health condition? ▢ Yes ▢ No

Previous Medications (Name, Reason, Dosage): ____

____

Current Medications (Name, Reason, Dosage): ____

____

	Poor	Fair	Good	Excellent
Rate the client's physical health.	▢	▢	▢	▢

List any physical or medical issues: ____

	Poor	Fair	Good	Excellent
Rate the client's sleep habits.	▢	▢	▢	▢

Describe any sleeping issues: ____

	Poor	Fair	Good	Excellent
Rate the client's eating habits.	▢	▢	▢	▢

Describe any eating/appetite issues:____

	Poor	Fair	Good	Excellent
Rate the client's mental health.	▢	▢	▢	▢

Please indicate your symptoms by checking the boxes that apply in the last six months:

▢ Sadness/Depression ▢ Excessive Worry ▢ Tearfulness ▢ Lack of Interest/Motivation ▢ Panic Attack
▢ Difficulty Sleeping ▢ Too Much Sleep ▢ Anger/Irritability ▢ Lack of Focus ▢ Self-Harm ▢ Suicidal Ideation
▢ Racing Thoughts ▢ Loneliness ▢ Shortness of Breath ▢ Restlessness/Shakiness ▢ Relationship Issues
▢ Difficulty Functioning at home, work, or school ▢ Headaches ▢ Withdrawn/Isolated ▢ Feeling paranoid
▢ Hearing/Seeing things that aren't there ▢ Intrusive thoughts ▢ Low Self-Esteem ▢ Hopelessness
▢ Restricting or Binging ▢ Flashbacks/Nightmares ▢ Bullying Behaviors ▢ Behavioral Issues ▢ Risky Behaviors
▢ Destructive to Property ▢ Aggression ▢ Difficulty following rules ▢ Difficulty taking direction ▢ School Refusal

List additional symptoms: ____

Patient Name:____

Please indicate stressors/traumas experienced within the last 2 years:

▢ Parent Divorce ▢ Loss of significant relationship ▢ Parent Job Loss ▢ Child Custody Issues ▢ Health Issues

▢ Death of immediate family member ▢ Loved One Health Issues ▢ Homelessness ▢ Financial Stress

▢ Domestic Violence ▢ Sexual Abuse ▢ Chronic Illness ▢ Changing Schools ▢ Moving ▢ Loss of Pet

▢ Serious Accident ▢ Separation from parent ▢ Witnessing a trauma ▢ Terminal Illness ▢ Bullying

▢ Poor School Performance ▢ Serious Injury ▢ Loss of Friendship ▢ Addiction of Loved One ▢ Harassment

▢ Incarceration of loved one ▢ Victim of Discrimination ▢ Stalking/Threats ▢ Witnessed Traumatic Event

▢ Victim of Violence ▢ Sexual Assault ▢ Victim of Crime ▢ Severe Mental Illness ▢ Mental Illness of Loved One

▢ Other: ____

Family Background:

Mother: Name: ____________________________Age: _________ Occupation: ______________________________

Describe Parent Child Relationships: ____

____

Father: Name: ______________________________Age: _________ Occupation: _____________________________

Describe Parent Child Relationships: ____

____

Are the client's parents married or still together? ▢ YES ▢ NO
If no, are there step parents or other partners involved with the client? If YES, Please provide names, length of relationship, and quality of relationship with the client.

____

____

List Siblings & Ages: ____

____

Please indicate any significant sibling relationship information. ____

____

____

Who lives with the client? ____

____

If applicable, what is the client's parenting time schedule? ____

____

____

Please list other family members who are significant in the client's life? (Of course pets count!)

____

Patient Name:____

Please list everyone who has a legal right to the client's medical information: (Clients 12 years and older have the right to confidentiality regarding information discussed in individual sessions.)

Name	Relationship to Client	Contact Information
___________________________	________________	__________________
___________________________	________________	__________________
___________________________	________________	__________________
___________________________	________________	__________________

Family Mental Health History

Check the boxes for all mental health conditions that are present within the client's family and list the relationships for each condition checked.

▢ Depression _____________________________ ▢ Anxiety ______________________________

▢ Bipolar ________________________________ ▢ Addition ______________________________

▢ Eating Disorder _________________________ ▢ Panic Attacks __________________________

▢ ADHD _________________________________ ▢ Schizophrenia _________________________

▢ PTSD _________________________________ ▢ Suicide ______________________________

▢ OCD __________________________________ ▢ Personality Disorder ____________________

Education Information

Current Grade or Last Grade Completed: _________ School Name: ______________________________

Does the client like school: ▢ Loves It ▢ It's OK ▢ Dislikes it

Average Grades: ▢ A's ▢ B's ▢ C's ▢ D's ▢ F's

Attendance: ▢ Never misses ▢ Sometimes misses ▢ Misses often ▢ Refuses to go to school

Social Functioning: ▢ Easily makes friends ▢ Has a friend or two ▢ Struggles making friends

Please list any clubs/sports/activities the client is involved in: ____________________________________

____

Please describe any difficulties the client is experiencing at school. _________________________________

____

Job Information (if applicable)

Does the client have a job? ▢ YES ▢ NO If so, where? _____________________________________

How long has the client worked there? _________________________ Position: ____________________

Job Satisfaction: ▢ Loves it ▢ It's okay ▢ Dislikes it ▢ Not Sure

Developmental, Emotional, and Behavioral Observations

Has the client experienced developmental delays in the past or currently? ▢ NO ▢ YES

If yes, please describe the client's experiences with developmental delays. (Include when the delays began, how long they lasted, how they impacted the client)

____

____

Patient Name:____

Has the client experienced any emotional difficulties? ▢ NO ▢ YES

If yes, please provide a description of emotional difficulties. (Include when difficulties began, how long they have lasted, how often they appear, and how they impact the client.)

____

____

____

Has the client experienced any behavioral issues? ▢ NO ▢ YES

If yes, please describe the client's behavioral issues. (Include when issues began, how long they have lasted, how often they appear, and how they impact the client.)

____

____

____

Substance Use/Abuse

Does the client live with anyone who has substance use/abuse? ▢ YES ▢ NO

If yes, please provide a description of the substance issues including who, what substances, and how the client has been affected.

____

____

____

Does the client have substance use/abuse issues? ▢ YES ▢ NO

If yes, please provide a brief description. ____

____

____

Additional Information

Hobbies/Interests: ____

Religious Affiliation: ____

What do you want us to know about the client? ____

____

____

Name of Person Completing this Form: ___________________________________

Relationship to the Client: ___________________________________ Date: ____________________