



# Child/Adolescent Intake Form

Ready for the World, LLC

Today's Date \_\_\_\_\_

## PERSONAL INFORMATION

PATIENT'S LEGAL NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ GENDER \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Parent Cell Phone \_\_\_\_\_ Child's Cell Phone (optional) \_\_\_\_\_

**Please indicate with an \* which phone numbers we may NOT leave a message.**

Email address to direct patient statement: \_\_\_\_\_

*Please review our Informed Consent, Information and Policies regarding use of email correspondence.*

FORM COMPLETED BY: \_\_\_\_\_ RELATIONSHIP TO MINOR \_\_\_\_\_

**RESPONSIBLE PARTY** \_\_\_\_\_ Responsible Party's SSN \_\_\_\_\_

*(If client is a minor, the responsible party is the parent or guardian bringing the minor for treatment and signing this form).*

If different from client:

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_

Name	Phone #	Relationship
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## INSURANCE INFORMATION

### PRIMARY INSURANCE

### SECONDARY INSURANCE

Policy Holder's Name \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Home address (if different) \_\_\_\_\_ Home address (if different) \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Insurance Company Name \_\_\_\_\_

Policy Holder's ID # \_\_\_\_\_ Policy Holder's ID # \_\_\_\_\_

Group # \_\_\_\_\_ Group # \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Name \_\_\_\_\_

## REFERRAL INFORMATION

How did you hear about Ready for the World/Maureen? (Please specify)

Family Member/Friend \_\_\_\_\_ Internet/Web Search \_\_\_\_\_

Therapist \_\_\_\_\_ School \_\_\_\_\_

Physician \_\_\_\_\_ Other \_\_\_\_\_

## Presenting Problem/Reason for Treatment

What is the primary reason you are seeking help ? \_\_\_\_\_

### CURRENT CONCERNS

Please check all of the symptoms below that are concerning:

<ul style="list-style-type: none"> <li><input type="checkbox"/> Loss of interest/not enjoying things</li> <li><input type="checkbox"/> Frequently negative thinking</li> <li><input type="checkbox"/> Decreased energy</li> <li><input type="checkbox"/> Difficulty concentrating</li> <li><input type="checkbox"/> Loss of appetite</li> <li><input type="checkbox"/> Sleep difficulties</li> <li><input type="checkbox"/> Thoughts of suicide</li> <li><input type="checkbox"/> Self-harm</li> <li><input type="checkbox"/> Bites nails</li> <li><input type="checkbox"/> Pulls own hair</li> <li><input type="checkbox"/> Dependent/needs a lot of reassurance</li> <li><input type="checkbox"/> Unable to sleep alone</li> <li><input type="checkbox"/> Difficulty coping with divorce/visitation schedule</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Easily distracted</li> <li><input type="checkbox"/> Reckless behavior/taking excessive risks</li> <li><input type="checkbox"/> Feeling overly important</li> <li><input type="checkbox"/> Racing thoughts</li> <li><input type="checkbox"/> Talkative</li> <li><input type="checkbox"/> Little need for sleep</li> <li><input type="checkbox"/> Very active/on the go all the time</li> <li><input type="checkbox"/> Impulsive behavior</li> <li><input type="checkbox"/> Temper tantrums</li> <li><input type="checkbox"/> Swearing</li> <li><input type="checkbox"/> Aggressive toward parents</li> <li><input type="checkbox"/> Assault</li> <li><input type="checkbox"/> Skips school</li> <li><input type="checkbox"/> Excessive anxiety about being away from caregivers</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Afraid of many things</li> <li><input type="checkbox"/> Experiencing panic attacks</li> <li><input type="checkbox"/> Avoiding going places/being with others</li> <li><input type="checkbox"/> Very shy</li> <li><input type="checkbox"/> Checking things repeatedly</li> <li><input type="checkbox"/> Need things to be perfect</li> <li><input type="checkbox"/> Overly fearful</li> <li><input type="checkbox"/> Sensitive to criticism</li> <li><input type="checkbox"/> Lacks confidence in abilities</li> <li><input type="checkbox"/> Sets fires</li> <li><input type="checkbox"/> Talks back to adults</li> <li><input type="checkbox"/> Plays alone most of the time</li> <li><input type="checkbox"/> Fights with other children</li> <li><input type="checkbox"/> Seems afraid of going to school</li> </ul>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Sad or unhappy most of the time</li> <li><input type="checkbox"/> Feeling helpless/hopeless</li> <li><input type="checkbox"/> Cries a great deal</li> <li><input type="checkbox"/> Moody</li> <li><input type="checkbox"/> Feeling empty inside/apathetic</li> <li><input type="checkbox"/> Afraid of being judged or rejected</li> <li><input type="checkbox"/> Angry/easily irritated</li> <li><input type="checkbox"/> Feelings of being worthless</li> <li><input type="checkbox"/> Disobeys parents</li> <li><input type="checkbox"/> Can't be trusted</li> <li><input type="checkbox"/> Immature</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Afraid of rejection</li> <li><input type="checkbox"/> Stomachaches/digestion issues</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Eating difficulties</li> <li><input type="checkbox"/> Body image difficulties</li> <li><input type="checkbox"/> Is a poor loser</li> <li><input type="checkbox"/> Untreated health problems</li> <li><input type="checkbox"/> Doesn't trust other people</li> <li><input type="checkbox"/> Bedwetting</li> <li><input type="checkbox"/> Bowel/toileting issues</li> <li><input type="checkbox"/> Has been a victim of bullies</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Concerns with alcohol use</li> <li><input type="checkbox"/> Concerns with drug use</li> <li><input type="checkbox"/> Picks on other children</li> <li><input type="checkbox"/> Tries to boss others around</li> <li><input type="checkbox"/> Has few or no friends</li> <li><input type="checkbox"/> Excessive use of video games or technology</li> <li><input type="checkbox"/> Pornography use</li> <li><input type="checkbox"/> Exhibits sexually inappropriate behavior</li> <li><input type="checkbox"/> Breaks things</li> </ul>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Difficulty remembering</li> <li><input type="checkbox"/> Confusion</li> <li><input type="checkbox"/> Rapid mood changes without cause</li> <li><input type="checkbox"/> Difficulty making decisions</li> <li><input type="checkbox"/> Feeling overwhelmed</li> <li><input type="checkbox"/> Difficulty controlling temper</li> <li><input type="checkbox"/> Trouble handling change</li> <li><input type="checkbox"/> Daydreaming</li> <li><input type="checkbox"/> Doesn't finish things</li> <li><input type="checkbox"/> Can't sit still/very active</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Feeling suspicious at times</li> <li><input type="checkbox"/> Having strange experiences</li> <li><input type="checkbox"/> Hearing voices/Seeing things</li> <li><input type="checkbox"/> Feels unsafe</li> <li><input type="checkbox"/> Hates going to school</li> <li><input type="checkbox"/> Is disrespectful toward teachers</li> <li><input type="checkbox"/> Feeling Bullied or picked on</li> <li><input type="checkbox"/> History of traumatic experiences</li> <li><input type="checkbox"/> Has been a victim of abuse</li> <li><input type="checkbox"/> Demands attention</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Trouble fitting in</li> <li><input type="checkbox"/> Learning problems</li> <li><input type="checkbox"/> Relationship problems</li> <li><input type="checkbox"/> Legal problems</li> <li><input type="checkbox"/> Refuses to do homework</li> <li><input type="checkbox"/> Stealing/lying</li> <li><input type="checkbox"/> Abusive toward others</li> <li><input type="checkbox"/> Thoughts of hurting others</li> <li><input type="checkbox"/> Runs away from home</li> <li><input type="checkbox"/> Cruel to animals</li> </ul>

Please describe any issues not listed above. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do these concerns impact daily life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anyone you want involved the treatment (i.e. teacher, pediatrician, relative, other organization)? \_\_\_\_\_  
\_\_\_\_\_

What do you consider to be strengths? \_\_\_\_\_  
\_\_\_\_\_

### Medical Information

Has the patient ever received inpatient or outpatient mental health services?  Yes  No

Where (Include name of therapist)?	When?	Was this helpful?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Primary Care Physician (Name/Practice): \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

List any current health concerns \_\_\_\_\_

Please list all current medications (attach another page if needed):

Name of Medication	Dosage/Amount/Frequency	Prescriber	Reason

Please describe any issues in early development that may be relevant. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### FAMILY INFORMATION

Are parents divorced or separated?     No             Yes

If yes, how long? \_\_\_\_\_

What are the current custody/visitation arrangements? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please tell us about the household/family. List primary household information first, then list other living situations/ supportive relationships:

Name	Age	Relationship to Client (spouse, domestic partner, child, parent, roommate)	Quality of Relationship	Living with patient?
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have any significant concerns about a relationship with a family member?    No     Not sure     Yes

If so, please describe your concerns. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have a family history of mental illness, addiction, or other issues that may be relevant? If so, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Substance Use**

Does the patient use/abuse substances?  Yes  No

Alcohol  Daily use  Occasional Use  None

Tobacco or electric cigarettes  Daily use  Occasional Use  None

Marijuana  Daily use  Occasional Use  None

Opiates  Daily use  Occasional Use  None

Other mood altering substances\*  Daily use  Occasional Use  None

\*Specify \_\_\_\_\_

Has alcohol/drug use interfered with family, work, health or interpersonal life?  Yes  No

If yes, please explain: \_\_\_\_\_

Have others viewed use as a problem?  Yes  No

If yes, please explain: \_\_\_\_\_

Substance abuse treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

Does a parent use/abuse substances?  Yes  No

If yes, please explain: \_\_\_\_\_

**Legal History**

Is there any involvement with the legal system, Friend of the Court or Child Protective Services?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you or your child currently on probation or parole?  Yes  No

Have you been involved with the legal system in the past?  Yes  No

**Education/Employment Information (Patient)**

Highest (or current) Grade Level Achieved: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_

Please describe any issues with school:

\_\_\_\_\_  
\_\_\_\_\_

Currently employed?  Yes  No If so, name of employer: \_\_\_\_\_

What is the expectation for the completion of chores? \_\_\_\_\_

\_\_\_\_\_

**Trauma History**

Is there a history of trauma, abuse or neglect?  Yes  No

If yes, what type of abuse or trauma occurred?  Physical  Sexual  Emotional  Neglect

Verbal  Other : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Treatment Goals**

What areas would you like addressed in therapy?

- Improve coping strategies
- Excessive conflict with siblings
- Decrease depression
- School resistance
- Improve social skills
- Resistance to doing chores
- Improve quality of life
- Issues with significant other
- Become more organized
- Feel better about self
- Take better care of self
- Deal with past trauma
- Eliminate abuse toward others
- Deal with divorce of parents
- Issues with parent(s)
- Decrease anxiety
- Deal with loss
- Substance use/abuse
- Sexual issues
- Sexual orientation
- Eliminate self-injury

Please briefly describe issues checked above and any other issues you may want to address: \_\_\_\_\_

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Electronic devices your child uses:  Phone  Ipod  Ipad  Tablet  Computer  Video Game System

What are the rules regarding electronic devices? \_\_\_\_\_

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What kind of discipline is used when house rules are broken? \_\_\_\_\_

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