Neuropsych
Associates

CHILD INTAKE FORM

Client Last Name: ______________________________ First Name: ___________________ Middle Initial: ______
Social Security Number: __________-_______-__________
Date of Birth: ____________________/_____________/______________ Gender: ________ Male ________ Female
Race: (Please Mark) ☐ White (Non Hispanic), ☐ Black (Non Hispanic), ☐ Hispanic, ☐ American Indian or Alaskan Native, ☐ Asian, ☐ Native Hawaiian or Other Pacific Islander, ☐ Multi-Racial
Address: ____ City: ______________________
State: ____________________________ County: _______________________________ Zip Code: ___________
Phone: Home ________________________ Cell ________________________ Work _______________________
Email Address: ____
If Client is a Child, is Child in Foster Care? Yes _____ No _____ If yes, is He or She with Siblings? Yes _____ No _____

Employer: _______________________________ Occupation: ____
Employer's Address: ____
Married: Yes ______ No ______ If yes, Name of Spouse: ____

Current Caregiver or Legal Guardian (Mark One) ☐ Parent ☐ Foster Parent

Other Relative: ____________________ Non Relative: ____________________ Facility: _____________________
Name: ____
Phone: Home ________________________ Cell ________________________ Work ________________________

Name and Address of Current School: ______________________________ Highest Grade Completed: ___________
School History: ____

Name of Client's Physician: ____
Physician's Address and Telephone: ____
Date of Last Visit with Physician: ____

Legal Guardian/Emergency Contact Information

(Mark all that apply) ☐ Self ☐ Same as Above ☐ Parent ☐ Other Relative ☐ Foster Parent ☐ DCM
Name: _________________________________
Address if Different from Client): ____
Phone: Home ________________________ Cell ________________________ Work __________________________
Employer: _______________________________ Occupation: ____
Employer's Address: ____
Primary Language at Home: ______________________________ Religious Preference: _______________________

TREATMENT AUTHORIZATION

I hereby authorize NeuroPsych Associates to provide therapy, counseling, or other services as deemed necessary for the client named above>

_____________________________________ ______________________
Signature of Client or Guarantor Date

Client Name: ____________________________________

List Present Household Members

Name	Age	Relation

Who referred you to NeuroPsych Associates? ____

What problems do you wish to address in counseling?

- ____
- ____
- ____

List any problems or difficulties that would prevent you from attending counseling.

- ____
- ____
- ____

Have you or your child received counseling or inpatient treatment before?

- When did problems begin? ____
- Where did problems occur? ____
- Please include time schedule of events ____
- Was the counseling/treatment effective? Yes _____ If "No" Please explain: ______________________________

  ____

Is there any history of legal problems? If yes, explain briefly:

- ____
- ____
- ____

List Hobbies, Talents, Enjoyable/Volunteer Activities:

- ____ ____
- ____ ____
- ____ ____

List all Peer and Community Supports (i.e. Church, School, and Friends):

- ____ ____
- ____ ____
- ____ ____

Client Name: ____________________________

SOCIAL HISTORY

- Place of birth (City, State): ____
- Did you (or the child's mother) have prenatal care? Yes ______ No ______
- How much did child weigh at birth? ________lbs. ________ oz.
- Were there any complications at birth? Yes ______ No ______
- At what age:
  - Walk? ________________________
  - Talk? ________________________
  - Toilet training? ________________

Describe Childhood:

- Environment ____
- Family Life ____
- Moving History ____
- Friends ____

Family Relationships: (Describe your relationship with each immediate/extended family member)

- Mother:
  - Name: ________________________________ Age: ________________
  - Occupation: ____
  - Relationship: ____
- Father:
  - Name: ________________________________ Age: ________________
  - Occupation: ____
  - Relationship: ____
- Grandparents:
  - Names: ________________________________ Ages: ________________
  - Occupations: ____
  - Relationships: ____
- Siblings:
  - Name: ________________________________ Age: ________________
  - Occupation: ____
  - Relationship: ____
  - Name: ________________________________ Age: ________________
  - Occupation: ____
  - Relationship: ____
  - Name: ________________________________ Age: ________________
  - Occupation: ____
  - Relationship: ____
  - Name: ________________________________ Age: ________________
  - Occupation: ____
  - Relationship: ____

Client Name: ____________________________

FAMILY HISTORY

Is there a family history of mental health problems? If yes, please explain.

- ______________________________
- ______________________________
- ______________________________

Is there a family history of any legal problems? If yes, explain briefly.

- ______________________________
- ______________________________
- ______________________________

PROBLEM BEHAVIORS CHECKLIST

School	Yes	No	Comments, times per day/week/month
Poor grades			
Difficulty paying attention			
Destructive behavior			
Disruptive behavior			
Does not follow rules			
Disrespectful to staff			
Wets self			
Soils self			
Fears going to school			
Skips class/school			
Suspension			

Home	Yes	No	Comments, times per day/week/month
Tantrums			
Bed wetting			
Bed soiling			
Plays with fire			
Stealing			
Lying			
Won’t follow instructions			
Physical/verbal aggression			
Damages property			
Running away			
Nightmares			
Eats too much			
Eats too little			
Sleeps too much/too little			

Community	Yes	No	Comments, times per day/week/month
Shoplifting/stealing			
Damage to property			
Poor choice of friends			
Involvement with legal system			

Client Name: ____________________________

Behavior towards others	Yes	No	Comments, times per day/week/month
Verbal aggression			
Physical aggression			
Cruelty to animals			
Thoughts/threats of killing others			
Argumentative			
Poor peer relations			
Withdraws from others			
Others take advantage of			

Moods/Emotions	Yes	No	Comments, times per day/week/month
Depressed/sad			
Crying spells			
Fearfulness			
Worries			
Nervous/irritable			
Angry			
Mood swings			
Easily upset			
Low energy			
Does not show feelings			

Self-Harmful Behavior	Yes	No	Comments, times per day/week/month
Puts self in dangerous situations			
Hurts/cuts self intentionally			
Thinks/talks of hurting self			
Attempted suicide			

Thinking	Yes	No	Comments, times per day/week/month
Forgetful/looses things			
Has memory loss			
Imagines things that aren't there			
Expresses odd beliefs/thoughts			
Suspicious/mistrusts others			
Odd or repetitive behaviors			
Poor judgment			

Physical	Yes	No	Comments, times per day/week/month
Unusual body movement/sounds			
Vomiting			
Headaches			
Stomachaches			
Other physical complaints:			
Accident prone			
Health problems/concerns			

Sexual	Yes	No	Comments, times per day/week/month
Masturbates in public			
Touches others inappropriately			
Exposes self to others			
Sexual behavior with objects			
Sexual behavior with animals			
Interest in pornography			
Preoccupation with sex			
Sexual talk/gestures			
Promiscuity			

Client Name: ___________________________

Allergies: Yes ______ No ______ List all known allergies (food, medicine, insects, etc.): ______________________________
____

Height: ____________ Weight ____________ lbs. General health: Good ______ Fair ______ Poor ______

Are you or your child currently under the care of a doctor? Yes ______ No ______, state the condition being treated: _______
____

Physician's Name: ________________________________ Address: ____

Please list medications, if any, that you, your child, or other family members take and for what reason: ___________________
____

Advance Directives: In case of an emergency and if you need to go to an area hospital, please indicate the hospital of choice:
____

MEDICAL CONDITIONS

Condition	Client	Family History (Parents, siblings, etc.)
Diabetes		
Stomach Ulcers		
Glaucoma		
Heart Trouble		
High Blood Pressure		
Nervousness		
Liver Disease		
Asthma/Emphysema		
Tumors		
Tuberculosis		
Kidney/Bladder Pain		
Bleeding Tendencies		
Rheumatism/Arthritis		
Thyroid Condition		
Anemia		
Seizures		
Gout		
Stroke		
Cancer		
Other		

Please mark any conditions/problems that apply:

- ☐ Dizziness
- ☐ Blackouts/seizures
- ☐ Ear drainage or pain
- ☐ Tired most of the time
- ☐ Lack of appetite/indigestion
- ☐ Lack of or unable to sleep
- ☐ Breathing difficulty
- ☐ Pregnancy
- ☐ Nausea/vomiting
- ☐ Nagging cough or hoarseness
- ☐ Sores that do not heal
- ☐ Recent weight change (+/- 10lbs in 30 days)
- ☐ Leg cramps/aches etc.
- ☐ Shaking hands, arms or legs
- ☐ Frequency/difficulty urinating
- ☐ Constipation or diarrhea
- ☐ Pain/stress
- ☐ Chills, fever, or night sweats

Other
____

Please list past surgeries or major hospitalizations (include dates) ____
____

Client Name: ___________________________

SUBSTANCE ABUSE HISTORY (11 AND OLDER)

Drug	Age of Onset	Longest Period of Sobriety	Date of Last Use	Current Amount and Frequency of Use
Caffeine				
Tobacco				
Alcohol				
Sedatives				
Hallucinogens				
Pain Killers				
Inhalants				
Cannabis				
Cocaine (+ Method)				
Crack Cocaine				
Heroin (+ Method)				
Ecstasy				
Special K				
Prescription Meds				

Related Problems

Alcohol	Drugs	
☐	☐	Interpersonal Problems
☐	☐	Binges
☐	☐	Job Problems
☐	☐	Sleep Disturbances
☐	☐	Physical Withdrawal
☐	☐	Hangovers
☐	☐	Arrests
☐	☐	Blackouts
☐	☐	Medical Complications
☐	☐	Assaults
☐	☐	Passing Out
☐	☐	Seizures
☐	☐	Concern over Use
☐	☐	Changes in Tolerance
☐	☐	Inability to Stop
☐	☐	Preoccupied w/obtaining

History of Treatment Attempts

Alcohol	Drugs	
☐	☐	None
☐	☐	Stopped on Own
☐	☐	Attended OP Program
☐	☐	Attended IP Program
☐	☐	Attended 12-Step Program
☐	☐	Attended Self-Help Group

Self Perception of Use

Alcohol	Drugs	
☐	☐	None
☐	☐	Experimental
☐	☐	Occasional or Social
☐	☐	Problems Use
☐	☐	Psychological Dependence
☐	☐	Does Not Want to Stop
☐	☐	Addicted/Cannot Stop
☐	☐	Motivated to Stop

I verify that the above information is correct: ____ _____/_____/_______

Signature **Date**