Main Office: 101 S. Central Ave. Oviedo, FL 32765
(407) 358- 7188

CHILD/ADOLESCENT INTAKE FORM

Parent/Guardian complete this section:

Parent(s)/Guardians Name:_____ Date: _____

Child/ Adolescent's Name: _____

Age: ___ Date of Birth: ___/___/_____ Sex: ___Male ___Female Phone: _____

Natural Child Yes/No If adopted at what age: _____ Foster since: _____

Address: _____

Two Emergency Contacts:

_____

Name Phone Relationship

_____

Name Phone Relationship

In case of an emergency, please *sign the line* provided to authorize Tree of Life Counseling Center & Foundation to contact the above emergency contacts: _____

Do you regularly attend a church, synagogue, or other religious institution? Yes ___ No ___

If yes, where do you attend? _____

How did you hear about Tree of Life Counseling Center & Foundation? _____

What has led you to seek counseling at the time? _____

Family History:

Parents:

Parents relationship Status:

Are parents married? Yes ___ No ___ if yes, length of marriage:

_____

Are parents divorced? Yes ___ No ___ if yes, how old was the child at time of divorce?

_____

Who has legal guardian ship? _____

Is there any significant information about the parents' relationship which might be beneficial to counseling: Yes ___ No ___

Mother:

Name: _____ Age: ____ Number of times married: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

May we contact client's mother? Yes ___ No ___

May we contact mother at **Home**: Yes___ No ___ **Work**: Yes ___ No ___ **Cell**: Yes___ No ___

How would you describe the mother's relationship with the child?

Excellent_____ Good_____ Fair_____ Poor_____

Father:

Name: _____ Age: ____ Number of times married: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

May we contact client's father? Yes ___ No ___

May we contact father at **Home**: Yes___ No ___ **Work**: Yes ___ No ___ **Cell**: Yes___ No ___

How would you describe the father's relationship with the child?

Excellent_____ Good_____ Fair_____ Poor_____

Does the Client have any step parents? Yes___ No___

Step Mother:

Name: _____ Age: ____ Number of times married: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

May we contact client's father? Yes ___ No ___

May we contact father at **Home**: Yes___ No ___ **Work**: Yes ___ No ___ **Cell**: Yes___ No ___

How would you describe the step mother's relationship with the child?

Excellent_____ Good_____ Fair_____ Poor_____

Step Father:

Name: _____ Age: ____ Number of times married: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

May we contact client's step father? Yes ___ No ___
May we contact father at **Home**: Yes___ No ___ **Work**: Yes ___ No ___ **Cell**: Yes___ No ___
How would you describe the father's relationship with the child?
Excellent_____ Good_____ Fair_____ Poor_____

Siblings and others in house hold:

Names of siblings (First and Last)	Age/Gender (#, M/F)	Lives (Home/ Away)	Relationship w/ client (Good/ Fair/ Poor)

*Please add additional siblings to the back of this form

Who are other significant people in your child's life?

Name (First and Last)	Age/Gender (#, M/F)	Lives (Home/ Away)	Relationship w/ client (Good/ Fair/ Poor)

Please describe any past counseling that either your child or any family member

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____
If yes, please describe:

Child's Behavior

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

_____
_____
_____

What does your child do that you like? What does he/she do that other people like?

_____
_____
_____

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet?

_____
_____
_____

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

_____
_____
_____

Education History:
What school does your child attend? _____

Address: _____

Phone: _____ Teacher's Name: _____
Current Grade: _____

What does your child's teacher say about him/her?

_____
_____

Other schools attended (including pre-school):

_____
_____

Has your child ever repeated a grade? If so which one(s)?

_____

Has your child ever received special education services? Yes ___ No ___
If yes, what kind of program?

_____

Has your child experienced any of the following problems at School?

Fighting	Lack of friends	Drug/Alcohol	Detention
Suspension	Learning Disabilities	Poor attendance	Poor grades
Gang influence	Incomplete homework	Behavior problems	

Medical History:
What is the name of your child's primary care physician? _____

Address: _____ Phone: _____

Date of your child's last medical examination: _____
Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones: _____
Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them: _____

_____

Has your child experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness	Other _____	

Please list any current medical problems or physical handicaps:

_____

_____

Please list any medications/vitamins, etc. your child takes on a regular basis:

_____

_____

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe: _____
_____

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else? If so, Please describe _____
_____
Has he/she ever purposely hurt himself or another? Yes ___ No ___
If yes, please describe:
_____

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain: _____
_____
Finally, what are some of the things that are currently stressful to your child and his/her family?
_____

PARENTAL/GUARDIAN CONSENT FOR TREATMENT OF MINOR(S)

Name of child/children for Consent: _____

Parent Name: _____ Date: _____

Signature: _____

Parent Name: _____ Date: _____

Signature: _____

Therapist Name: _____ Date: _____

Signature: _____