

Hillcrest Family Services- Outpatient Services Child/Adolescent Client Information

Thank you for taking time to fill out the following confidential information. The information provided will assist us in providing you quality services.

Intake Date: _____

CLIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Birthdate: ___/___/___ Social Security #: _____ Gender: male female

Address: _____
Street Apt# City State Zip

School: _____ Grade Level: _____ Special Education yes no

Have you been notified of any behavioral difficulties at school? yes no

If so, please explain:

Who is child's legal guardian? _____

Who has legal custody of child? _____

Emergency Contact: _____
Name Phone Relationship

FAMILY INFORMATION

Mother's Name: _____ DOB: _____ Employer: _____ Position: _____

Address: same _____
Street Apt# City State Zip

Primary Contact Phone _____ home cell work other Okay to leave message? yes no

Secondary Contact Phone _____ home cell work other Okay to leave message? yes no

Father's Name: _____ DOB: _____ Employer: _____ Position: _____

Address: same _____
Street Apt# City State Zip

Primary Contact Phone: _____ home cell work other Okay to leave message? yes no

Secondary Contact Phone: _____ home cell work other Okay to leave message? yes no

Who lives in your child's home?

Full Name	Relationship	Age	Education level	Employer/School

Was there a period when your child was separated from you? yes no

Are there are other family members important to your child who do not live with him/her? yes no

First and Last Name	Relationship

Please check all characteristics that apply to your child:

- | | |
|--|--|
| <input type="checkbox"/> Abnormal thoughts/perceptions | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Anger outbursts | <input type="checkbox"/> No appetite |
| <input type="checkbox"/> Anxiety/nervousness | <input type="checkbox"/> Obsessions/compulsions |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Oppositional |
| <input type="checkbox"/> Change in friends | <input type="checkbox"/> Perfectionist |
| <input type="checkbox"/> Concerns with sexual activity | <input type="checkbox"/> Physical abuse history |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Poor self-control |
| <input type="checkbox"/> Decreased energy & motivation | <input type="checkbox"/> Problems with concentration |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Problems with eating |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Runs away |
| <input type="checkbox"/> Doesn't follow directions | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Drinking/drug use | <input type="checkbox"/> Sexual abuse history |
| <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stomach trouble |
| <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Feelings of inferiority | <input type="checkbox"/> Thoughts of hurting others |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Thoughts of hurting self |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Traumatic experience |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> increased aggression | <input type="checkbox"/> Trouble making or keeping friends |
| <input type="checkbox"/> Interest in setting fires | <input type="checkbox"/> Unable to relax |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Other |

Identify any other concerns/issues: _____

DEVELOPMENTAL HISTORY

Were there complications with your pregnancy or your child's birth? yes no

Please explain: _____

Did your child require special attention in first weeks or month of life? yes no

Please explain: _____

Did your child meet developmental milestones (sitting, crawling, walking, toileting, etc.) within normal time span? yes no

Please explain: _____

During the first 3 years of life, your child:

	Frequently	Sometimes	Rarely
Cried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had extreme mood changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty adapting to new people and places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injured himself/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enjoyed being held	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was alert to environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interacted with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Intellectual/Academic Functioning (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> normal intelligence | <input type="checkbox"/> authority conflict | <input type="checkbox"/> refusal to attend |
| <input type="checkbox"/> high intelligence | <input type="checkbox"/> attention problems | <input type="checkbox"/> anxious at school |
| <input type="checkbox"/> learning disability | <input type="checkbox"/> underachieving | <input type="checkbox"/> peer conflicts |

Age/Grade problems occurred: _____

Social Interaction (check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> normal social interaction | <input type="checkbox"/> aggressive | <input type="checkbox"/> argues excessively | <input type="checkbox"/> lack of respect for others |
| <input type="checkbox"/> isolates self | <input type="checkbox"/> rejected by peers | <input type="checkbox"/> problems making friends | <input type="checkbox"/> destructive |
| <input type="checkbox"/> very shy | <input type="checkbox"/> problems sharing | <input type="checkbox"/> problems keeping friends | <input type="checkbox"/> doesn't follow rules |
| <input type="checkbox"/> inappropriate sex play | <input type="checkbox"/> poor boundaries | <input type="checkbox"/> poor decision-making | |

PREVIOUS TREATMENT HISTORY

Has your child had significant medical issues in the past ? yes no
Please list:

Has your child seen other mental health professionals? yes no Please list with dates: _____

Has your child been hospitalized? yes no Please list with dates: _____

Please list any major family changes (death, separation/divorce, move, traumatic event, etc.): _____

Please print your name: _____ Relationship to child: _____