

**Agape Psychological Consortium, PLLC
Intake Form (Child/Adolescent)**

Child's First Name: _____ Middle Name: _____ Last Name: _____ Intake Date: _____
Primary Insurance: _____ Secondary Insurance: _____
Gender: Female Male Race: _____ DOB: _____ Age: _____

Parent/Legal Guardian Name: _____ Relationship to child: _____
Marital Status (check all that applies): Single Married Partnered Separated Divorced Widowed
Address: _____ City: _____ State: _____ Zip Code: _____
Guardian's phone (primary): _____ (Phone Provider): _____ email: _____

Group Home/Out of Home Placement Information:

Program Name: _____ Admission Date: _____
Administrator/Contact Person: _____ Phone #: _____

Reason(s) for seeking services (please be specific):

Who referred you to Agape? _____
Problem #1: _____
Problem #2: _____
➤ Type of services needed (please check one): Therapy Evaluation Both Consultation
➤ Previously seen at Agape Psychological Consortium: Yes No If yes, when: _____

Counseling/Treatment Experiences:

	<u>Yes</u>	<u>No</u>	<u>When</u>		<u>Yes</u>	<u>No</u>	<u>When</u>		<u>Yes</u>	<u>No</u>	<u>When</u>
Currently	_____	_____	_____	Previous	_____	_____	_____	Hospitalization	_____	_____	_____
Has anyone else in your family been diagnosed or seen a therapist for emotional problems? <input type="checkbox"/> Yes <input type="checkbox"/> No											

Pertinent Developmental and Family History:

List all family members, and "family-like", people living in the home:

<u>Name</u>	<u>Relationship to child</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other family members who are not in the home (e.g., parent, brothers, sisters):

<u>Name</u>	<u>Relationship to child</u>	<u>Age</u>	<u>Location</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were there any unusual/traumatic experiences/events that seriously affected your child's life? Yes No
If yes, what happened: _____
With your child, has there been any history of abuse, neglect, or violence? Yes No
If yes, which type(s)? Sexual: _____ Physical: _____ Verbal: _____ Emotional: _____ Domestic Violence: _____
Any past or current DSS involvement: Yes No If yes, when: _____ Why: _____

Psychiatric/Medical/Physical Health:

With your child - Previous psychiatric hospitalizations: Yes No
Health or physical concerns: Yes No; Developmental concerns: Yes No; Medications: Yes No
History of head injury: Yes No; Allergies: Yes No
Previous/Current psychiatric diagnoses (if any): _____

Educational History:

Name of current school: _____ Current Grade: _____
Has your child ever: Been diagnosed with a learning disability or ADHD? Yes No
Received special education services or had an IEP? Yes No
Had any major recent changes in his/her grades? Yes No
Been evaluated: Yes No Been suspended or expelled from school: Yes No

Legal Issues:

Current legal problems: Yes No Charges: _____ Current status: _____
Past legal problems: Yes No Charges: _____ Current status: _____

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Special Considerations:

Currently seeking SSI or disability for your child? Yes No
Required by court, social services, probation, or school to have this appointment? Yes No
Currently involved in any type of custody or child support dispute involving your child? Yes No

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Alcohol/Chemical Use History:

Does your child currently use alcohol or other non-prescribed drugs: Yes No
Has your child ever used alcohol or other non-prescribed drugs: Yes No
Has anyone in your family had a problem with drugs or alcohol? Yes No

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Lethality History:

Has your child ever had thoughts of killing himself/herself? Yes No When: _____
Has your child ever attempted to commit suicide? Yes No When: _____ How: _____
Has your child ever had any thoughts about hurting others? Yes No When: _____
Has your child ever attempted to hurt someone else? Yes No When: _____ How: _____

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Treatment Plan:

With each of your presenting problems, what specific goal would you like your child to work on in therapy?
Problem #1: _____
Problem #2: _____

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Referral: Who referred you to Agape Psychological Consortium?

Name: _____ Phone: _____
If known, name of practice or program: _____
May I have your permission to thank this person for the referral? Yes No

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Medical Care: If your child was referred by his/her medical doctor, may I contact him/her so that he/she can be fully informed of your child's care and to coordinate treatment? Yes No If yes, please complete:

➤ Primary Care Physician: _____ Phone #: _____
➤ Name of Practice: _____ Address: _____

Emergency Contact: If for some unforeseen reason, you have an emergency, and someone needs to be contacted, may we contact the person to coordinate your child's care? Yes No If yes, complete the following:

Emergency Contact Person: _____ Phone #: _____

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Authorization:

As legal guardian of this particular minor client, I have the legal authorization to give Agape Psychological Consortium permission to:

- Provide evaluation/therapeutic services to my child: Yes No
- Provide appointment reminders by text and/or email: Yes No

Guardian's Signature: _____ Date: _____