Coastal Synergy
ASSOCIATES

INTAKE FORM FOR CHILD/ADOLESCENT SERVICES

Child's name: _____ DOB: _____ Age_____

Child primarily lives with: ___ Both parents ___ Mother ___ Father ___ Other _____

Mother's name: _____ DOB: _____

Address: _____

Phone: (C) _____ (H) _____

Employer: _____

Please list others living in mother's home, ages, and relationship to child:

_____
_____
_____

Father's name: _____ DOB: _____

Address: _____

Phone: (C) _____ (H) _____

Employer: _____

Please list others living in father's home, ages, and relationship to child:

_____
_____
_____

Who has legal guardianship of your child?
_____

Please describe custody and the child's current living arrangements:

_____

_____

Is there any legal involvement with your child? Yes _____ No _____ If so, please describe:

_____

_____

Please bring copies of any court orders that impact your child.

Reason(s) for seeking services:

_____

_____

_____

_____

What goals do you have for services?

_____

_____

_____

_____

CHECK ANY ISSUES YOU HAVE OBSERVED FOR YOUR CHILD

	Mild	Moderate	Severe		Mild	Moderate	Severe
Sleep issue - falling asleep	☐	☐	☐	Hopelessness	☐	☐	☐
Sleep issue - staying asleep	☐	☐	☐	Helplessness	☐	☐	☐
Anger	☐	☐	☐	Impulsivity	☐	☐	☐
Anxious	☐	☐	☐	Irritability	☐	☐	☐
Bingeing/Purging	☐	☐	☐	Isolation	☐	☐	☐
Concentration problems	☐	☐	☐	Hyperactivity	☐	☐	☐
Delusions	☐	☐	☐	Mania	☐	☐	☐
Depressed mood	☐	☐	☐	Memory problems	☐	☐	☐
Decreased energy	☐	☐	☐	Mood lability	☐	☐	☐
Flashbacks	☐	☐	☐	Nightmares	☐	☐	☐
Grief	☐	☐	☐	Obsessions/compulsion	☐	☐	☐
Guilt	☐	☐	☐	Panic attacks	☐	☐	☐
Hallucinations	☐	☐	☐	Restricted eating	☐	☐	☐
Homicidal	☐	☐	☐	Sexual problems	☐	☐	☐

Suicidal thoughts	☐	☐	☐
Tearfulness	☐	☐	☐
Worthlessness/Low self-esteem	☐	☐	☐
Weight Gain	☐	☐	☐
Weight Loss	☐	☐	☐
Other	☐	☐	☐

PSYCHOSOCIAL HX

Where was your child born? _____

Financial Stressors

☐ Yes

☐ No

Prenatal/Perinatal/Development History & Events

☐ Premature

☐ Lack of oxygen

☐ Drug use

☐ Alcohol use

☐ Low birth weight

☐ Other_____

_____

FAMILY Hx

Relationship with Mother

☐ Yes

☐ No

☐ Adopted

☐ Biological

Describe_____

_____

Relationship with Father

☐ Yes

☐ No

☐ Adopted

☐ Biological

Describe_____

_____

Grade/School _____

Relationship with Siblings

○ Yes

○ No

Describe_____

_____

Relationship with Stepparent(s)

○ Yes

○ No

Describe_____

_____

PSYCHOSOCIAL STRESSORS

Lost important relationships

○ Yes

○ No

Describe_____

_____

Accident w/ Injury Hx

○ Yes

○ No

Describe_____

_____

Health

☐ Good

☐ Fair

☐ Poor

Describe_____

Death in Family

- Yes
- No

Who/When/ How _____

_____

Legal Problems

- Yes
- No

Describe_____

_____

Self Injury Hx

- Yes
- No

Describe_____

_____

SUBSTANCE ABUSE/USE HX

- None
- Nicotine
- Caffeine
- Alcohol
- Cocaine
- Benzodiazepines
- Cannabis
- Opiates
- Barbiturates
- Ecstasy
- LSD
- Other

Past Substance Treatment

- Yes
- No

Describe_____

_____

Past Mental Health Treatment

- Yes
- No

Describe_____

_____

Family Hx of Mental Illness or Substance Use/Abuse

- Yes
- No

Describe_____

_____

Abuse Hx - Victim

- None
- Emotional
- Physical
- Sexual
- Other

Describe_____

_____

Abuse reported

- Yes
- (•) No

Describe_____

_____

Abuse History - Perpetrator

- Denied
- Emotional
- Physical
- Sexual
- Other

Describe_____

_____

Abuse reported

- Yes
- No

Describe_____

_____

Suicidal Thoughts

- [ ] None
- [ ] Thoughts
- [ ] Plan
- [ ] Intent

Describe_____

_____

Homicidal Thoughts

- [ ] None
- [ ] Thoughts
- [ ] Plan
- [ ] Intent

Describe_____

_____

Current Medications

- ○ Yes
- ○ No

List:_____

_____

_____

_____

_____

Coastal Synergy
ASSOCIATES

CONSENT FOR TREATMENT OF MINOR(S) AND OTHERS

I _____ (guardian's name) give my consent that Coastal Synergy Associates will be conducting services with _____ (minor's name).

My relationship to the client is (parent, uncle, grandparent, etc.):
_____.

I was also notified that all material discussed during the sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form, which I have read and signed.

In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept my clinician's judgment in regard to releasing or sharing information obtained during the course of treatment with the minor that may endanger or jeopardize the client's wellbeing.

In case of emergency, please notify:

Name: _____ Phone: _____ Relationship: _____

_____	_____	_____	_____
Name (print)	Relationship	Signature	Date

_____	_____	_____	_____
Name (print)	Relationship	Signature	Date