Better Solutions Counseling Center

Child/Adolescent Intake Developmental History Record

Child's name: _____ Birthdate: _____Age: _____

Person(s) completing this form: _____ Today's date: _____

Primary reason(s) for seeking services:

❑ Anger management ❑ Anxiety ❑ Coping ❑ Depression
❑ Eating disorder ❑ Fear/phobias ❑ Mental confusion ❑ Sexual concerns
❑ Sleeping problems ❑ Addictive behaviors ❑ Alcohol/drugs ❑ Hyperactivity
❑ Other mental health concerns (specify): _____

A. Identifications

1. Mother's name: _____ Birthdate: _____Home phone: _____

Address: _____

Currently employed: ❑ No ❑ Yes, as: _____ Work phone: _____

2. Father's name: _____ Birthdate: _____Home phone: _____

Address: _____

Currently employed: ❑No ❑Yes, as: _____ Work phone: _____

3. Parents are currently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Other: _____

Child currently lives with: _____ Legal guardian is: _____

4. Stepparent's name: _____ Birthdate: _____ Home phone:_____

Address: _____

Currently employed: ❑No ❑Yes, as: _____ Work phone: _____

5. Other adult family members? _____

_____

6. Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ❑No ❑Yes If Yes, describe: _____

_____

Client Name _____

B. Siblings:
Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	❑ F ❑ M	❑ home ❑ away	❑ poor ❑ average ❑ good
_____	___	❑ F ❑ M	❑ home ❑ away	❑ poor ❑ average ❑ good
_____	___	❑ F ❑ M	❑ home ❑ away	❑ poor ❑ average ❑ good
_____	___	❑ F ❑ M	❑ home ❑ away	❑ poor ❑ average ❑ good

Others living in the household (Name)	Age	Gender	Relationship (e.g., cousin, foster child)	Quality of relationship with the client
_____	___	❑ F ❑ M	_____	❑ poor ❑ average ❑ good
_____	___	❑ F ❑ M	_____	❑ poor ❑ average ❑ good
_____	___	❑ F ❑ M	_____	❑ poor ❑ average ❑ good
_____	___	❑ F ❑ M	_____	❑ poor ❑ average ❑ good
_____	___	❑ F ❑ M	_____	❑ poor ❑ average ❑ good

Comments: _____

_____

C. Development
Please fill in any information you have on the areas listed below.
1. Pregnancy and delivery

Prenatal medical illnesses and health care: _____

_____

_____

Was the child premature? ❑ No ❑ Yes. Weight and height at birth: _____ pounds/oz. _____ inches

Any birth complications or problems? _____

_____

2. The first few months of life

Breast-fed? If so, for how long? Any allergies? _____

_____

_____

_____

Sleep patterns or problems: _____

_____

_____

Personality: _____

_____

Client Name _____

3. Milestones: At what age did this child do each of these?

Sat without support: _____ Crawled: _____ Walked without holding on: _____

Helped when being dressed: _____ Tied shoelaces: _____ Buttoned buttons: _____

Ate with a fork: _____

Stayed dry all day: _____ Didn't soil his or her pants: _____ Stayed dry all night: _____

4. Speech/language development

Age when child said first word understandable to a stranger: _____

Age when child said first sentence understandable to a stranger: _____

Any speech, hearing, or language difficulties? _____

_____

D. Health Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents)
Check those which apply:

Self	Relative		Self	Relative		Self	Relative	
❑	❑	Allergies	❑	❑	Eczema	❑	❑	Nose Bleeds, severe
❑	❑	Anemia	❑	❑	Encephalitis	❑	❑	Paralysis
❑	❑	Asthma	❑	❑	Fevers, severe	❑	❑	Perceptual motor disorder
❑	❑	Blackouts	❑	❑	Glandular problems	❑	❑	Pneumonia
❑	❑	Bleeding tendency	❑	❑	Hayfever	❑	❑	Pleurisy
❑	❑	Blindness	❑	❑	Heart diseases	❑	❑	Pneumonia
❑	❑	Bronchitis	❑	❑	Hepatitis	❑	❑	Polio
❑	❑	Cancer	❑	❑	High blood pressure	❑	❑	Retardation, Mental
❑	❑	Cerebral Palsy	❑	❑	Hives	❑	❑	Rheumatic Fever
❑	❑	Chicken Pox	❑	❑	Influenza	❑	❑	Scarlet Fever
❑	❑	Cleft lips	❑	❑	Kidney disease	❑	❑	Seizures
❑	❑	Cleft palate	❑	❑	Lead poisoning	❑	❑	Sexually Transmitted Diseases
❑	❑	Colds, severe	❑	❑	Mental illness	❑	❑	Skin Rashes
❑	❑	Congenital problems	❑	❑	Measles	❑	❑	Spinal Bifida
❑	❑	Deafness	❑	❑	Meningitis	❑	❑	Suicide
❑	❑	Diabetes	❑	❑	Migraines	❑	❑	Thyroid Disorders
❑	❑	Diphtheria	❑	❑	Multiple sclerosis	❑	❑	Vision problems/Glasses
❑	❑	Dizziness	❑	❑	Mumps	❑	❑	Whooping Cough
❑	❑	Ear aches	❑	❑	Muscular Dystrophy	❑	❑	Other: _____
❑	❑	Ear Infections	❑	❑	Nervousness			_____

Client Name _____

List other childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

Comments: _____

_____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination		
Dental examination		
Vision examination		
Hearing examination		

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio
2 months	___	___
4 months	___	___
6 months	___	___
18 months	___	___
4–5 years	___	___

15 months _____ MMR (Measles, Mumps, Rubella)

24 months _____ HBPV (Hib)

Prior to school _____ HepB

Client Name _____

E. Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	❑ None ❑ Little ❑ Medium ❑ A lot
Lunch	____ / week	_____	❑ None ❑ Little ❑ Medium ❑ A lot
Dinner	____ / week	_____	❑ None ❑ Little ❑ Medium ❑ A lot
Snacks	____ / week	_____	❑ None ❑ Little ❑ Medium ❑ A lot

Comments: _____

F. Child's Residences

1. Homes

From	To	Location	With whom	Reason for moving	Any problems?

2. Residential placements, institutional placements, or foster care

From	to	Program name or location	Reason for placement	Problems?

G. Schools

School (name, district, address, phone)	Grade	Age	Teacher

May I call and discuss your child with the current teacher? ❑ Yes ❑ No

Feelings about School Work:

❑ Anxious ❑ Passive ❑ Enthusiastic ❑ Fearful
❑ Eager ❑ No expression ❑ Bored ❑ Rebellious
❑ Other (describe): _____

Approach to School Work:

❑ Organized ❑ Industrious ❑ Responsible ❑ Interested
❑ Self-directed ❑ No initiative ❑ Refuses ❑ Does only what is expected
❑ Sloppy ❑ Disorganized ❑ Cooperative ❑ Doesn't complete assignments
❑ Other (describe): _____

Performance in School (Parent's Opinion):

❑ Satisfactory ❑ Underachiever ❑ Overachiever
❑ Other (describe): _____

Client Name _____

Child's Peer Relationships:

❑Spontaneous ❑Follower ❑Leader ❑Difficulty making friends

❑Makes friends easily ❑Long-time friends ❑Shares easily

❑Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ❑Mother ❑Father ❑Shared ❑Other (specify): _____

Health: ❑Mother ❑Father ❑Shared ❑Other (specify): _____

Problem behavior: ❑Mother ❑Father ❑Shared ❑Other (specify): _____

H. Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.: _____

_____

_____

I. Discipline

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

J. Other

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

❑ Yes ❑ No If Yes, describe: _____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

Any additional information that would assist us in understanding current concerns or problems?

_____

_____

What are your goals for the child's therapy?

_____

_____

What family involvement would you like to see in the therapy?

_____

_____

Do you believe the child is suicidal at this time? ❑ Yes ❑ No If Yes, explain:

_____

_____