Rhonna W. Phillips
Counseling & Therapy Services, LLC

PSYCHOSOCIAL HISTORY FOR CHILD/ADOLESCENT INTAKE ASSESSMENT
Primary Caregiver to provide the needed information on these pages. Part A

Intake Date _____
Child/Adolescent's legal name _____Goes by _____
DOB _____ Age ____ Driving Y/N Gender:_____ Any culture specific needs _____
Lives w/ _____Phone: _____
Address _____
Legal Custodian _____ School _____ FT/PT Work _____ FT/PT Other _____ Your name/role: _____
Home phone _____ Cell Phone _____
Bio Siblings names/ages_____ Step/Half siblings_____

Your primary concerns about the child/adolescent "_____ _____"

DEVELOPMENT:
Was there Substance Abuse during this child's conception or pregnancy? Y/N _____How was the Pregnancy _____ Full term Y/N _____ Baby's weight _____
As a baby did he/she have any of these problems? Disliked to be held ____, Feeding ____, Over sensitivity to Light/Noise/temperature? _____, Restlessness _____, Sleeping ____, Fussy _____, Colic _____, Head banging _____, difficulty Bonding _____Other _____.

What age did this Toddler achieve these developmental milestones? Crawling _____, Sitting Up _____, Walking _____, Putting words together _____, Potty trained _____. Did he/she have any unusual behaviors? Spinning_____, Hand flapping _____, repeating words _____, referring to others as "I" _____, excessive use of other senses ie: Smelling and Tasting _____. Did he/she attend Pre-School or Day Care? _____ Any other odd behaviors? _____.

EDUCATION:
Attended Elementary School age _____ Any problems with Behavior, Learning, or Social relationships? _____. In Middle/Junior High School were there any problems with Behavior, Grades, or Social interactions? _____.
In High School were there any problems with Conduct, Grades, or relationships_____.

Any evaluations done for Academic concerns? _____ were Special Education Services or an IEP provided? _____What adult was the primary participant? _____ Did he /she suspect learning problems? _____ Post High School training? _____.

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MEDICAL/MENTAL HEALTH HISTORY:
Primary Care Dr _____ Phone _____ Chronic conditions _____ past Head Injury Y/N_____, Major surgeries _____.

Y/N- Been to Psychiatric Hospital ____, Psychiatrist ____, prescribed Mental Health Rx _____, Counseling _____, Other _____.

Medicine on now:
_____ for _____ Dr. _____ ph _____
_____ for _____ Dr. _____ ph _____
_____ for _____ Dr. _____ ph _____
_____ for _____ Dr. _____ ph _____

Describe any Suicidal, Self Injurious, or Homicidal behavior you suspect or are aware of past or present _____
_____.

LEGAL:
Alternative School ____, CHINS ____, DUI _____ Charges _____ Jail _____ Court Date _____ Probation _____ Other _____
Biological parents divorced y/n. Please provide a copy of the court order showing custody and visitation orders. Provided y/n _____

Thank you for sharing this important information about your loved one.

Please note if your adolescent is age 14 or over he/she will legally have the choice as to whether to include any adult in his/her treatment. Both custodial and non-custodial parents have rights to information about their child's treatment but at age 14yo+ it is up to the adolescent.

Please ask the child/adolescent to complete the next page, part B, & bring both A & B to our first session. Each section will provide me valuable insight into the problem and I will be better able to help your child/adolescent as quickly as possible.

_____ _____
Your signature Date Rev 05-2016

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PSYCHOSOCIAL HISTORY FOR CHILD/ADOLESCENT INTAKE ASSESSMENT
To be completed by the Child or Adolescent on own. Part B
Date _____

Name you go by _____ Gender identity: _____
How shall I reach you? Phone _____ Text: Yes/No _____
Mail _____ Email _____
Contact in case of emergency _____ phone _____

What is your concern "_____"

What problems are you experiencing? When did each start?

Emotions _____ _____

Thoughts _____ _____

Attitude _____ _____

Behavior _____ _____

Attention _____ _____

Relationships _____ _____

Using a severity scale of 1 (best) – 10 (worst) how unhappy or stressed are you? ____
Check which situations are causing this: School ____ Work ____ Home ____ Family_____
Friends/peers _____ (male or female) Other adults ____ Health/Medical____ Other _____
Office Note: _____

What led to or caused this problem? _____.

Have you experienced any Abuse? Verbal ____, Emotional ____, Physical ____ Sexual ____
Office Note: _____.

How have you Coped? Sleeping _____, Ignoring _____, Avoiding _____, Skipping School or Work _____, Running Away _____, Pushing people away _____, Praying _____, Stating your Feelings & Needs _____, Yelling _____, Arguing _____, Talking to: friends, other family, siblings, or other adults _____, Focusing on Activities _____, Diving into wk or school or other _____ Refusing to Cooperate _____, Doing Alcohol or Drugs _____, Acting Out _____, Being Sexually Promiscuous _____, Binge Eating _____, Restricting Eating/Foods _____, Purging _____, Exercising _____ (excessive?), Self Harm_____, Suicide Attempts ____, Threatening to assault/harm others _____, Other _____
_____

_____ _____
Your signature Date Rev. 05-2016

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PSYCHOSOCIAL HISTORY FOR CHILD/ADOLESCENT INTAKE ASSESSMENT
Part C Staff

OFFICE NOTES: _____

_____

_____

_____

_____

Dimensional description of client presentation:_____

_____

Internalizing/Externalizing factors: _____

Psycho-social & contextual factors: _____

ICD 10 CM Z codes: _____ _____

Diagnostic impression or see Sx Assessment: _____

_____

PLAN: _____

HMWK: _____

RTC: _____

_____ _____
Rhonna W. Phillips, MA **Date**
Licensed Professional Counselor & Supervisor
Licensed Marriage and Family Therapist
Collaborative Practitioner
Qualified Family & Domestic Relations Mediator **Rev. 05-2016**