Family Resource Center
Thriving Families. Nurtured Children.

122 North Laurel Drive, Clarksville, GA 30523 Office: 706-778-3100 - Fax: 706-928-5183

CHILD/ADOLESCENT INTAKE INFORMATION

This Form is Confidential

Today's Date: _____

Child's Name: _____
Last First Middle Initial

Age: _____ Date of birth: _____ Gender: _____

Grade: _____ School: _____

Name of person completing this form: _____

Your relationship to child: _____

Best contact phone # for you: _____ Indicate: ____ Cell ____Home ____Work

May we contact you at this #? ____ Yes ____No If cell, may we text? ____ Yes ____ No

Calls will be discreet, but please indicate any restrictions: _____

Email: _____ Can we email you at this address? ____ Yes ____No

Parent or Legal Guardian's Name: _____
Last First Middle Initial

Home street address: _____

City: _____ State: _____ Zip: _____

Phone # if different than yours: _____

Occupation: _____ Employer: _____

With whom does child live? _____

Their relationship to child? _____

Person(s) to notify in case of any emergency: _____ Phone # _____

Relationship to child: _____

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so:

(**Your Signature**): _____

Is child in foster care? ____ Yes ____ No If yes, for how long? _____

If adopted, does child know of adoption? ____Yes ____ No What age was your child at the time of adoption? _____

Please check all that apply to your child and CIRCLE the main problem:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			Tantrums →			Nausea →		
Depression			Parents Divorced			Stomachaches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic Attacks			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues Re: Divorce			Sweating		
Memory Problems			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Social Isolation		
Communicating with Others			Acts of Violence/ Feelings of Hostility			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self/Others			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Strange Thoughts/Behaviors		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

- ☐ Drug/Alcohol Problems
- ☐ Legal Trouble
- ☐ Domestic Violence
- ☐ Suicide
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Hyperactivity
- ☐ Learning Disabilities
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric Hospitalization
- ☐ "Nervous Breakdown"

Social Support, Self-Care and Education:

	Poor						Excellent
Child's current level of satisfaction with friends and social support:	1	2	3	4	5	6	7

How would you describe your child's relationships with his/her peers?

_____

_____

Please briefly describe any history of abuse, neglect and/or trauma:

_____

_____

_____

Please briefly describe your child's self-care and coping skills:

_____

_____

What are your child's diet, weight, and exercise/activity patterns?

_____

_____

Please briefly describe your child's school performance and experience:

_____

_____

_____

What are your child's hobbies, talents, and strengths?

_____

_____

History of Concern

Please describe what concerns you have regarding your child:

_____

_____

Have there been any previous incidents of the current concern? If yes, please describe:

_____

_____

How long has the concern existed?

_____

_____

Have there been any significant stressors or change for the family: losses, births, deaths, moves, hospitalizations, financial problems, recently or in the last several years?

_____

_____

What attempts have been made to resolve the concerns?

_____

_____

Legal or custody concerns:

_____

_____

What are your/your child's goals for therapy?

_____

_____

Have you discussed these goals with child?

_____

_____

Sexual and Gender Identity: ____ Heterosexual ____ Lesbian ____ Gay ____ Bisexual
____ Transgender ____ Asexual ____ In Question ____ Other

Racial/Ethnic Identity:

____African/African-American/Black ____ Bi-Racial/Multi-Racial ____ White/European-American
____American Indian/Alaska Native ____ Latino/Latino-American ____ Not Listed
____Asian/Asian-American/Asian Pacific Islander ____ Middle Eastern/Middle Eastern-American

Child's Medical History

Please explain any significant medical problems, symptoms, or illnesses your child has had:

_____

_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons):

_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):

_____

_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons):

_____

_____

Family Dynamics

How would you describe your child's relationship with his or her mother?

_____

_____

How would you describe your child's relationship with his or her father?

_____

_____

Are the child's parents still married or did they divorce? _____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her?

_____

_____

Please describe your child's relationships with his/her grandparents:

_____

_____

_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life:

_____

_____

_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?

_____

_____

_____

Current living situation: (Who lives in the home currently?)

_____

_____

_____

Family History

FAMIY PSYCHIATRIC HISTORY/**PARENTS**: Please Indicate: F/Father, M/Mother, O/Other

____ADD/ADHD	____Alcoholism	____Psychosis
____Antisocial Features	____Depression	____Schizophrenia
____Anxiety	____Domestic Abuse	____Sleep Disturbance
____Bipolar	____Panic Disorder	____Substance Abuse
____Bereavement	____Phobic Disorder	____Suicide/Attempts
____Conduct Disorder/Disruptive	____PTSD	____Treatment/Inpatient

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements.)

_____

_____

_____

Is ex-spouse (biological parent) aware that you are bringing their children to counseling? ____Yes ____No

If not please explain:

_____

_____

_____

Name of person who referred you to Family Resource Center/PCAH? _____

Agency: _____

If involved with other agencies, please complete below.

Please provide information for the agencies you give permission to PCAH and your counselor to release information on the client's behalf during the course of treatment.	
Agency	**Caseworker Name & Contact Information**
Law Enforcement	
DFCS	
Guardian Ad Litem	
Attorney	
Other:	
Other:	

I give permission to my counselor and PCAH to release information to the above listed agencies during my treatment.

I also give these agencies permission to share information with PCAH and my counselor during my treatment.

____Yes ____No

Parent/Guardian: _____Date: _____

Signature: _____

If for minor, print child's name: _____

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Client Agreement for Acceptance of Services

By initialing and signing below you agree with all the terms and services provided by the ***Counseling Program*** of the Family Resource Center-Prevent Child Abuse Habersham.

Policies and Procedures:

_____ Please initial that you have read the policies on appointment cancellations and the procedures for contacting your therapist in the *Welcome Packet (pg. 1).*

_____ Please initial if you have been informed on the location of the HIPPA *Notice of Privacy Practices* at the Family Resource Center Annex.

_____ Please initial here if you have read the emergency services phone numbers in the *Welcome Packet (pg. 2) .*

Litigation Policy:

I understand that the Family Resource Center and all its contracted therapists are not custody evaluators and cannot make any recommendations on child custody cases *(pg. 3 of the Welcome Packet).* I also understand that in the event the Family Resource Center's policy regarding subpoenas and court appearances is disregarded *(or waived– even by the court),* I will be billed for the FULL STANDARD FEE for all court-related work: $400/hour for all professional time. This includes preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance, and any time spent waiting at the court house in addition to time on the stand, as well as any travel time etc.

_____

Print Client's Name

_____ Date: ____/____/____

Signature of Client, Parent, Guardian or Personal Representative

_____ Date: ____/____/____

Signature of Therapist

Consent for Treatment

Your signature below indicates that you have read and understand the information as stated in the *Welcome Packet* and that by this consent form you give permission to the Family Resource Center to provide counseling services. This contract is binding for all future sessions you may have with this entity.

_____ Date: ____/____/____

Signature of Client, Parent, Guardian or Personal Representative

_____

If you are signing as a personal representative of an individual, please describe (above ↑) *your authority to act for this individual (parent, guardian, power of attorney, healthcare surrogate, etc.).*