

**The Attachment and Trauma Center of Nebraska
Child and Teen Intake Form**

Name _____ Date of 1st Appointment _____ Therapist _____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

School _____ Grade _____ Key Teacher/School counselor _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Current medications being taken:

1) _____ Dosage/Freq _____ Start Date _____ Purpose _____

2) _____ Dosage/Freq _____ Start Date _____ Purpose _____

3) _____ Dosage/Freq _____ Start Date _____ Purpose _____

4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Has your child ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital Mo/Yr Reason

Describe any important medical history, chronic ailments, or other health problems your child experiences: _____

Does your child have a learning or physical disability? (Circle One) YES NO MAYBE. Describe: _____

Does your child have a mental health diagnosis? (Circle One) YES NO MAYBE. Describe: _____

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments: _____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

DEVELOPMENTAL and FAMILY HISTORY

In the first two years of life, did your child experience:

Separation from mother, Out of Home care, Disruption in bonding, Depression of mother,
 Abuse, Neglect, Chronic pain, Chronic Illness, Parental Stress

Reached developmental milestones: On Time, Early, Late

How many times has the child moved homes? _____

What are five adjectives that describe:

Mother: _____

Father: _____

Child: _____

Parental Relationship: _____

Biological Dad: _____ DOB: _____ Biological Mom: _____ DOB: _____

Married: ___/___/___; Separated: ___/___/___; Divorced: ___/___/___

Siblings (1st to last) Name: _____ Age _____

Name: _____ Age _____ Name: _____ Age _____

Name: _____ Age _____ Name: _____ Age _____

Custodial Adults (if not biological parents): Dad: _____ DOB: _____

Mom: _____ DOB: _____ Date became caretaker: _____

People in household, if different from above: _____

Does father work outside the home? Yes No; Occupation: _____ Hours: _____

Father's highest level of education? _____

Does mother work outside the home? Yes No; Occupation: _____ Hours: _____

Mother's highest level of education? _____

If separated or divorced, visitation schedule: _____

Does either parent have legal issues? If YES, Describe _____

Does your family have any specific spiritual or religious beliefs? If YES, Describe _____

List any mental illness or addiction in immediate or extended family (For example: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, eating disorders, ADHD, Schizophrenia) _____

Have your children witnessed domestic violence? Yes No. If Yes, describe: _____

How is your child disciplined? Please list each method and frequency of use: _____

ACADEMIC AND SOCIAL HISTORY

ACADEMIC PERFORMANCE

Highest grade on last report card? _____

Lowest grade on last report card? _____

Favorite subjects in school? _____

Least favorite subjects? _____

Has your child had special testing in school? (If YES, please describe below)

Psychological ___YES ___NO Learning ___YES ___NO Vocational ___YES ___NO

What would your child like to do about school at this point?

___Quit school ___Graduate from High School ___Go to College

In school, how many friends does your child have? ___ a lot ___ a few ___ none

Does child have friends in the neighborhood or close cousins they play regularly with? ___YES ___NO

Describe: _____

How does your child handle anger with peers and family? _____

What are your child interests, hobbies and regular activities? _____

How much time does your child play on the computer, watch TV or play video games? _____

Has your child ever had difficulty with the Police?

Has your child ever appeared in Juvenile Court?

Has your child ever been on Probation?

| Dates | Reason | Probation Officer |
|-------|--------|-------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has your child ever been employed?

| Dates | Employer | Job |
|-------|----------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

TRAUMA HISTORY

Has your child been verbally abused? ___Yes ___No ___Suspected Describe: _____

Has your child been physically abused? ___Yes ___No ___Suspected Describe: _____

Has your child been sexually abused? ___Yes ___No ___Suspected Describe: _____

Other stressors or traumas? _____

CONCERNS, STRENGTHS AND GOALS

Circle the symptoms your child displays and list the number of times per week the symptom is displayed:

- | | | | |
|--|---------------------|---------------------|-------------------------------|
| Anger | Anxiety | Bedwetting | Acts out sexually |
| Conduct problems | Controlling | Day defecation | Has unusual sexual knowledge |
| Day Wetting | Defiance | Depression | Homicidal thoughts or actions |
| Disassociates | Drug or Alcohol use | Hyperactivity | Masturbates excessively |
| Hyper-vigilance | Impaired conscience | Isolation | Lack of empathy |
| Lack of motivation | Lethargy | Low impulse control | Plays out violent themes |
| Low self-esteem | Lying | Nightmares | Plays out sexual themes |
| Obsesses | Over/Under eating | Phobias | Peer Problems |
| Phobias | Running away | Shy | Self-mutilating |
| Sleeping problems | Suicide talk | Stealing | Tantrums |
| Somatic symptoms: headaches, stomachaches, etc | | | |

OTHER Concerns: _____

Has the child experienced any significant loss? If Yes, Describe: _____

What do you view as your child's major strengths and positive traits? _____

Describe your goals for your child's therapy: _____

What else is important for your therapist to know about your child and your family? _____

Thank you for taking the time to complete this form. This information helps us have a strong start in helping your family.