Staff: Client #:_____ Insur. Verified:_____ Registered:_____ Pic:_____ Consent/PCP: _____ F/U Letter: _____

Agape Psychological Consortium

Intake Form (Child/Adolescent)

Child's First Name: _____ Middle Name:_____ Last Name: _____ Intake Date: _____
Primary Insurance: _____ Secondary Insurance: _____
Gender: Female ___ Male ___ Race: _____ DOB: _____ Age: ___

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Parent/Legal Guardian Name: _____ Relationship to child: _____
Marital Status (check all that applies): Single ____ Married ____ Partnered ____ Separated ____ Divorced ____ Widowed ___
Address (if different than child): _____ City: _____ State: NC
Guardian's phone (primary): _____ (Secondary): _____ email: _____

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Group Home/Out of Home Placement Information:
Program Name: _____ Admission Date: _____
Administrator/Contact Person: _____ Phone #: _____

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Reason(s) for seeking services (please be specific):
Who referred you to Agape? _____
Problem #1: _____
Problem #2: _____

- Type of services needed (please check one): ❑ Therapy ❑ Evaluation ❑ Both ❑ Consultation
- Previously seen at Agape Psychological Consortium: ❑ Yes ❑ No If yes, when: _____

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Counseling/Treatment Experiences:

	Yes	No	When		Yes	No	When		Yes	No	When
Currently	___	___	_____	Previous	___	___	_____	Hospitalization	___	___	_____

Has anyone else in your family been diagnosed or seen a therapist for emotional problems? ❑ Yes ❑ No

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Pertinent Developmental and Family History:
List all family members, and "family-like", people living in the home:

Name	Relationship to child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other family members who are not in the home (e.g., parent, brothers, sisters):

Name	Relationship to child	Age	Location
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were there any unusual/traumatic experiences/events that seriously affected your child's life? ❑ Yes ❑ No
If yes, what happened: _____
With your child, has there been any history of abuse, neglect, or violence? ❑ Yes ❑ No
If yes, which type(s)? Sexual: ___ Physical: ___ Verbal: ___ Emotional: ___ Domestic Violence: ___
Any past or current DSS involvement: ❑ Yes ❑ No If yes, when: _____ Why: _____

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Psychiatric/Medical/Physical Health: With your child, any current:
Health or physical concerns: ❑ Yes ❑ No; Developmental concerns: ❑ Yes ❑ No; Medications: ❑ Yes ❑ No
List any prescribed medications: _____
History of head injury: ❑ Yes ❑ No; Allergies: ❑ Yes ❑ No; Previous psychiatric diagnoses: ❑ Yes ❑ No

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Educational History:

Name of current school: _____ Current Grade: _____

Has your child ever: Been diagnosed with a learning disability or ADHD? ❑ Yes ❑ No

Received special education services or had an IEP? ❑ Yes ❑ No

Had any major recent changes in his/her grades? ❑ Yes ❑ No

Been evaluated: ❑ Yes ❑ No Been suspended or expelled from school: ❑ Yes ❑ No

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Legal Issues:

Current legal problems: ❑ Yes ❑ No Charges: _____ Current status: _____

Past legal problems: ❑ Yes ❑ No Charges: _____ Current status: _____

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Special Considerations:

Currently seeking SSI or disability for your child? ❑ Yes ❑ No

Required by court, social services, probation, or school to have this appointment? ❑ Yes ❑ No

Currently involved in any type of custody or child support dispute involving your child? ❑ Yes ❑ No

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Alcohol/Chemical Use History:

Does your child currently use alcohol or other non-prescribed drugs: ❑ Yes ❑ No

Has your child ever used alcohol or other non-prescribed drugs: ❑ Yes ❑ No

Has anyone in your family had a problem with drugs or alcohol? ❑ Yes ❑ No

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Lethality History:

Has your child ever had thoughts of killing himself/herself? ❑ Yes ❑ No When: _____

Has your child ever attempted to commit suicide? ❑ Yes ❑ No When: _____ How: _____

Has your child ever had any thoughts about hurting others? ❑ Yes ❑ No When: _____

Has your child ever attempted to hurt someone else? ❑ Yes ❑ No When: _____ How: _____

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Treatment Plan:

With each of your presenting problems, what specific goal would you like your child to work on in therapy?

Problem #1: _____

Problem #2: _____

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Referral: Who referred you to Agape Psychological Consortium?

Name: _____ Phone: _____

If known, name of practice or program: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

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Medical Care: If your child was referred by his/her medical doctor, may I contact him/her so that he/she can be fully informed and we can coordinate your child's treatment? ❑ Yes ❑ No If yes, please complete:

Primary Care Physician: _____ Phone #: _____

Name of Practice: _____ Address: _____

Emergency Contact: If for some unforeseen reason, you have an emergency and someone needs to be contacted, may we contact the person to coordinate your child's care? ❑ Yes ❑ No If yes, complete the following:

Emergency Contact Person: _____ Phone #: _____

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Authorization:

As the legal guardian of this particular minor client, I authorize Agape Psychological Consortium permission to provide evaluation/therapeutic services to my child:

Guardian's Signature: _____ Date: _____