Able Mediation and Counseling Services, Inc.

FAMILY INTAKE PACKET

***1. Parent's Name*:** _____ DOB: _____

Address (City, State and Zip):_____

Marital Status: _____ Male/Female: _____

Phone: H (____) _____W (____) _____ C (____) _____

OK to say AMSCI? Yes ❒No ❒

Emergency contact (name and phone#)_____

***2. Parent's Name*:** _____ DOB: _____

Address (City, State and Zip):_____

Marital Status:_____ Male/Female: _____

Phone: H(____)_____W(____)_____C(____)_____

OK to say AMSCI? Yes ❒ No ❒

Emergency contact (name and phone#)_____

3. *Step Parent(s)/Guardian(s)*:_____ DOB: _____

Address: _____

City, State and Zip: _____Marital Status: _____ Male/Female:____

Phone: H(____)_____W(____)_____C(____)_____

OK to say AMSCI? Yes ❒ No ❒

Emergency contact (name and phone#)_____

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Child's Name: _____ Age: _____ DOB: _____

Child's Name: _____ Age: _____ DOB: _____

Child's Name: _____ Age: _____ DOB: _____

****

History of Problem

Please describe what concerns you have regarding your family: _____

_____

_____

_____

How long has the problem existed? _____

_____

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

_____

_____

_____

What attempts have been made to resolve the difficulties? _____

_____

Please check the symptoms that the child is currently experiencing. Please indicate to which family member you are referring, as well as duration, and severity.

Severity of Symptom
None= 0 Mild=1 Moderate=2 Severe=3

Symptom	**How Long**	**Severity**
Sadness or Depression		
Suicidal Thoughts		
Sleep Problems		
Changes in Appetite		
Weight Change		
Lack of Concentration		
Obsessive thoughts		
Tension and Anxiety		
Panic Attacks		
Memory Problems		
Compulsive Behaviors		
Anger		
Acts of Violence		

Contd.

Severity of Symptom
None=0 Mild=1 Moderate=2 Severe=3

Symptom	How Long	Severity
Social Isolation		
Strange Thoughts		
Stomach Aches		
Head Aches		
Bed Wetting		
Phobias		
Other Behavior Issues		

Parent Information

Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, etc)? _____

_____

_____

_____

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 AMCSI? Yes ❒ No ❒

If not, please explain. _____

_____

_____

If adopted, does child know of adoption? Yes ❒ No ❒

What age was your child at the time of the adoption? _____

Mother's Name: _____ Age: _____

Employed: Yes ❒ No ❒ Occupation: _____

Employer's name and address: _____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Current and past psychiatric treatment or counseling:_____

Currently prescribed medications:_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use: _____

History of arrest: _____

Primary Care Physician: _____

Psychiatrist: _____

Father's Name: _____ Age: _____

Employed: Yes ❒ No ❒ Occupation: _____

Employer's name and address: _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications:_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use: _____

History of arrest: _____

Primary Care Physician: _____

Psychiatrist: _____

Step-parent/Guardian: _____ Age: _____

Employed: Yes ❒ No ❒ Occupation: _____

Employer's name and address: _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use: _____

History of arrest: _____

Primary Care Physician: _____

Psychiatrist: _____

Child Information:

1). Name of Child: _____ Age: _____ Child lives with: _____

School: _____ Grade: _____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____

2). Name of Child: _____ Age:_____ Child lives with:_____

School:_____ Grade:_____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency)_____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____

3). Name of Child: _____ Age:_____ Child lives with:_____

School:_____ Grade:_____ Teacher: _____

History of psychiatric treatment or counseling:_____

Current or past drug or alcohol use (indicate past or present amount, frequency)_____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____