Able Mediation and Counseling Services, Inc.

ADOLESCENT/ CHILD INTAKE FORM

Child's Name: ________________________________ Age: _________ DOB: ___________________

Sibling: ______________________________________ Age: _________ DOB: ___________________

Sibling: ______________________________________ Age: _________ DOB: ___________________

Sibling: ______________________________________ Age: _________ DOB: ___________________

Sibling: ______________________________________ Age: _________ DOB: ___________________

***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 #**) _____________________________

****

History of Problem

Please describe what concerns you have regarding your child: ___________________________________

____

____

____

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: ____