

Please note: You are free to skip any questions which you prefer not to answer.
If additional space is needed, please use the back of this form.



PSYCHOLOGICAL & COUNSELING SERVICES, PC

Offering a Full Range of Psychological & Counseling Services

12728 Augusta Avenue, Suite 150 Omaha, NE 68144 (402)330-1537

NEW CLIENT INTAKE FORM (CHILD OR ADOLESCENT)

TO BE COMPLETED BY THE PARENT/ GUARDIAN. PLEASE PROVIDE THE FOLLOWING INFORMATION.

TODAY'S DATE: _____

CLIENT NAME: _____

DATE OF BIRTH: _____

HOME ADDRESS (INCLUDE ZIP): _____

PREFERRED CONTACT NUMBER: _____ LEAVE MESSAGES AT THIS NUMBER? Y N

ALTERNATE CONTACT NUMBER: _____ LEAVE MESSAGES AT THIS NUMBER? Y N

RACE/ETHNICITY: _____

RELIGIOUS IDENTIFICATION (IF ANY): _____

SCHOOL/ GRADE: _____

CURRENTLY EMPLOYMENT (IF ANY): _____ POSITION: _____

PARENT RELATIONSHIP STATUS: MARRIED PARTNERED DIVORCED/ SEPARATED

NAME OF PARTNER/ SPOUSE: _____ DURATION OF RELATIONSHIP: _____

SIBLINGS (NAMES, AGES, EDUCATION STATUS): _____

CUSTODY STATUS (IF APPLICABLE): _____

LIST EVERYONE WHO LIVES AT YOUR HOME: _____

PRESENTING PROBLEM/ REASON FOR APPOINTMENT: _____

HAVE YOU EVER SOUGHT HELP FOR THIS CONCERN BEFORE? IF SO, WITH WHOM? WHEN? _____

FAMILY OF ORIGIN

PLACE OF BIRTH: _____

HOW WOULD YOU DESCRIBED THE HOME ENVIRONMENT (CURRENTLY, AS WELL AS IN THE PAST)? _____

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ANY SIGNIFICANT TRAUMA GROWING UP? _____
PHYSICAL ABUSE? _____ SEXUAL ABUSE? _____
DOMESTIC VIOLENCE BETWEEN PARENTS? _____
COMPLICATIONS DURING PREGNANCY/ DELIVERY? _____
UNUSUAL CHILDHOOD DEVELOPMENT/ MILESTONES? _____

ACADEMIC HISTORY

CURRENT GRADE POINT AVERAGE (IF UNKNOWN, DESCRIBE TYPICAL GRADES): _____
WHAT IS SCHOOL LIKE FOR YOUR CHILD? _____
ANY HISTORY OF ATTENTION OR BEHAVIOR PROBLEMS? _____
ANY DIAGNOSED LEARNING OR SPEECH DISABILITIES? _____
PARTICIPATION IN RESOURCE, SPECIAL EDUCATION, OR GIFTED PROGRAMS? _____
FAMILY HISTORY OF ACADEMIC/ LEARNING PROBLEMS? _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____ DATE OF LAST CHECKUP: _____
CURRENT MEDICATIONS, REASON TAKING, PRESCRIBING DR.: _____

CHRONIC ILLNESSES? _____
SURGERIES PAST, PLANNED? _____
EMERGENCY ROOM TRIPS? _____

PSYCHIATRIC HISTORY

PRIOR COUNSELING, CLINICIAN SEEN: _____
CURRENT OR PAST PSYCHOTROPIC MEDICATIONS: _____
HOSPITALIZATIONS/ TREATMENT STAYS (DATE, LOCATION): _____
PAST DIAGNOSES: _____
PAST SUICIDE ATTEMPTS: _____

LEGAL HISTORY

PAST LEGAL CHARGES/ CONVICTIONS: _____
PENDING CHARGES: _____
CHILDHOOD LEGAL DIFFICULTIES: _____
CHILDHOOD CONDUCT PROBLEMS (fighting, lying, stealing): _____
CURRENT DIVORCE/ CUSTODY ACTIONS (INCLUDE WHEN INITIATED AND BY WHOM): _____

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SYMPTOM CHECKLIST

Place a check mark next to the following symptoms that you have noticed in your child. For EACH symptom checked, please note the **FREQUENCY** (0=Never, 1=Sometimes, 2=Often), the **SEVERITY** (1-10 from least to most problematic) and **LENGTH OF TIME** your child has been experiencing this.

- Depressed mood
 - Feeling hopeless
 - Social withdrawal
 - Lack of interest in previously enjoyed activities
 - Changed sleep patterns (too much or too little)
 - Changed appetite (too much or too little)
 - Difficulty concentrating
 - Irritability

 - Obsessive thoughts
 - Social anxiety
 - Panic attacks (check relevant symptoms):
 - palpitations, pounding heart, or accelerated heart rate
 - sweating
 - trembling or shaking
 - sensations of shortness of breath or smothering
 - feeling of choking

 - Careless, poor attention to details
 - Difficulty sustaining attention
 - Unable to listen to others
 - Difficulty organizing
 - Tend to avoid effortful tasks
 - Often lose necessary things
 - Easily distracted

 - Relationship difficulties
 - Internet overuse
 - Defiant behavior/ arguing with adults
- Fatigue
 - Thoughts of suicide
 - Mood swings
 - Recklessness
 - Thoughts of suicide
 - Suicide attempts
 - Self-harm (cutting, self-mutilating)
 - chest pain or discomfort
 - nausea or abdominal distress
 - feeling dizzy, unsteady, lightheaded, or faint
 - feelings of unreality or being detached from oneself
 - fear of losing control or going crazy
 - fear of dying
 - numbness or tingling sensations
 - chills or hot flashes
- Forgetful in daily activities
 - Fidgety, unable to sit still
 - Always on the go
 - Acts as if driven by motor
 - Talking excessively
 - Difficulty waiting turn
 - Impulsive/ acts without thinking first

 - Truancy/ running away
 - Illegal activities
 - Fighting

Drug/ Alcohol Use (what used, how much, last time used): _____

Other symptoms not noted above: _____
