16 Clarke Street, Suite 21
Lexington, MA 02421
Tel: 781.402.2442
Fax: 781.402.1744

277 Main Street
Marlborough, MA
Tel: 508.787.1048

Child and Adolescent Intake Form

Child's Name: ____

Date of Birth: ____

Today's Date: ____

Reasons for Treatment

***Referral Source:* ____**

What does your child currently do too often, too much, or at the wrong times that gets him/her into trouble and/or is cause for concern? Be as specific as possible:

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What does your child fail to do as often as you would like, as much as you would like, or when you would like? Be as specific as possible:

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What does your child do that you like? What does he/she do that other people like?

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List any other concerns about your child or family that have not yet been mentioned.

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Treatment Goals

From your previous list of your child's behaviors and family concerns, list the top three areas you would like to see change. How will you know this change has occurred?

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Family History

(*include births, divorce, losses, transitions, moves, illness etc.)*

Who has legal guardianship? ____

If parents are separated or divorced, list the current visitation agreement:

____

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____

List name and age of siblings:

____

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List name and age of any other individuals living in the home:

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Developmental Milestones (crawling, walking, talking, toilet training) note any delays or complications:

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List child's primary caregiver(s) from birth to age 3:

____

Does anyone in the child's family use any type of drug, tobacco or alcohol (currently or in the past)? ☐ Yes ☐ No
If yes, please describe.

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____

Medical History

(illness, surgery, anything requiring ongoing treatment)

List any medications taken on a regular basis:

____

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____

____

Did the mother smoke tobacco or use any alcohol, drugs or medications during pregnancy? ☐ Yes ☐ No

If so which ones?

____

____

____

Were there any complications during pregnancy? ☐ Yes ☐ No

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____

Educational History

What school does your child attend? ____

Current Grade: ________

Please describe your child's overall school experiences including typical grades, socialization, use of special education services, hobbies, transitions, challenges, disciplinary action:

Grades 1 – 5

____

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____

____

Grades 6 – 8

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Grades 9 – 12

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Counseling History

Describe any past experience your child and/or family have had in counseling:

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Describe any history of psychiatric hospitalization:

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Describe any history of psychotropic medication:

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