Individual, Couple & Family Psychotherapy
Serving Belle Plaine, Burnsville, Cologne, Eden Prairie, Glencoe & Litchfield
925 12th St E, Ste 101; Glencoe, MN 55336
320.864.6139 | 952.361.9700 | fax: 320.864.6130
www.thejonascenter.com

Child and Adolescent Intake

Date:_____ Name:_____ Home Phone:_____

Address:_____

Okay to leave messages/reminder calls?_____ Date & Place of Birth:_____

Legal Guardians:_____

PARENTAL INFORMATION

Mother's Name	*Father's Name*	*Marital Status*	
Mother's Address		*Home Phone*	*Work Phone*
Father's Address		*Home Phone*	*Work Phone*

SIBLING INFORMATION

(Denote Step, Half, Foster, etc.)

Name	*Age*	*Sex*	*Address*
Name	*Age*	*Sex*	*Address*
Name	*Age*	*Sex*	*Address*
Name	*Age*	*Sex*	*Address*
Name	*Age*	*Sex*	*Address*

SCHOOL INFORMATION

School	*Address*	*Phone*

MEDICAL INFORMATION

Primary Care Physician/Clinic:_____

Address:_____

Phone:_____ Date of last exam:_____

List major health problems/disabilities/hospitalizations:_____

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List all current prescribed medicines with dosages:

List any known allergies to drugs or medicines:

List any over-the-counter medicines used regularly:

MAIN PROBLEM

What is the main problem for which you are seeking help for your child?

How long has it been a problem?

What previous mental health treatment has been tried - Was it helpful?

Previous mental health provider(s) with address/phone (if known):

List current medicines used for emotional problems w/ dosage – Are they helpful?

List any medicines previously used for emotional problems w/ dosage – Were they helpful?

What major stresses or changes have occurred in your child's life?

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Include moves, job loss or changes, divorce, illnesses, deaths, trauma, legal problems, abuse issues, or alcoholism in family. Also mention major stresses for other family members, such as accidents, illnesses, job loss, etc.

Which people are the most important in your child's life?

Comments about custody, visitation or other legal issues (if applicable):

CHEMICAL HEALTH INFORMATION

Have you ever thought your child's chemical use was a problem (describe)?

Alcohol? Yes/no

Cigarettes? Yes/no

Caffeine? Yes/no

Other drugs? Yes/no

Has previous chemical dependency treatment been tried and was it helpful?

Treatment facility with address/phone (if known):

Parents or other family members' use of alcohol, caffeine, or other drugs:

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SYSTEM OR PROBLEM LIST

Mark each symptom below with either a yes or a no if the symptom is concerning to you:

	Yes	No	How Long?		Yes	No	How Long?
Depression or Sadness	___	___	_____	Forgetfulness	___	___	_____
Loss of Interest	___	___	_____	Disoriented or Confused	___	___	_____
Sleep Problems or Nightmares	___	___	_____	Personality Changes	___	___	_____
Appetite Changes	___	___	_____	Hallucinations	___	___	_____
Irritable or Short Tempered	___	___	_____	Short Attention Span	___	___	_____
Withdrawn	___	___	_____	Impulsive	___	___	_____
Fatigue or Low Energy	___	___	_____	Cannot Sit Still	___	___	_____
Guilty Feelings	___	___	_____	Easily Distractible	___	___	_____
Change in Activity Level	___	___	_____	Binging or Purging	___	___	_____
Headaches or Stomachaches	___	___	_____	Excessive Concern with Appearance	___	___	_____
Self-Harming Behaviors	___	___	_____	Destructive or Fighting	___	___	_____
Mood Swings	___	___	_____	In Trouble with Law	___	___	_____
Nervousness	___	___	_____	Other Dangerous Behaviors	___	___	_____
Anxiety or Panic Attacks	___	___	_____	Family Problems	___	___	_____
Excessive Worry or Stress	___	___	_____	Social Problems	___	___	_____
Negative Thoughts or Other Fears	___	___	_____	Sexual Behaviors or Problems	___	___	_____
Other Obsessions/Compulsions	___	___	_____	Work or School Problems	___	___	_____

Other concerns/comments: _____

_____

What are your child's strong points, strengths and interests? _____

_____

_____

Signature of person completing the form *Relationship* *Date*