THE CHRYSALIS GROUP INC.
CHILD/ADOLESCENT INTAKE ASSESSMENT

Date _____

Child's Name: _____ Gender: □M □ F

Child's Birth Date: _____ Age: _____ Grade: _____

Race: _____ Religious Affiliation: _____

Information supplied by (name and relationship to client): _____

Child's custodian/guardians(s) is/are: _____

Child's Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone No.: _____ Cell Phone Numbers: _____

Is it OK to contact you/child at home? □N □Y Is it OK to leave a message? □N □Y

Email address: _____

Referred by _____ ___Friend ____ Family ____Professional ___ Other

Presenting Problem(s) or why you are seeking treatment: _____

_____

_____

MOTHER'S INFORMATION

Mother's Name: _____ Date of Birth: _____ Home Phone: _____

Other Phone: _____ Race/Ethnicity: _____ Religious Affiliation: _____

Address: _____

Marital/Relationship Status (Check One):
□ Married □ Live with Partner □ Single □ Separated □ Divorced
□ Widowed □ Other: _____

If married/partnered or living with someone other than the child's father, please provide the name of that person here: _____

Employment (Check One):
□ Employed □ Retired □ Disabled □ Student □ Stay-at-home Parent
□Unemployed

If/When employed, what type of work? _____

Current employer: _____

Years at current job: _____ Work Phone: _____

Is it OK to contact at work: □N □Y OK to leave a message: □N □Y

FATHER'S INFORMATION

Father's Name: _____ Date of Birth: _____Home Phone:_____

Other Phone: _____Race/Ethnicity: _____Religious Affiliation:_____

Address: _____

Marital/Relationship Status (Check One):
□ Married □ Live with Partner □ Single □ Separated □ Divorced
□ Widowed □ Other: _____

If married/partnered or living with someone other than the child's father, please provide the name of that person here:_____

Employment (Check One):
□ Employed □ Retired □ Disabled □ Student □ Stay-at-home Parent
□Unemployed

If/When employed, what type of work?_____

Current employer:_____

Years at current job:_____Work Phone: _____

Is it OK to contact at work: □N □Y OK to leave a message: □N □Y

REASON FOR SEEKING TREATMENT

Please briefly describe the problems your child is experiencing:_____

_____

_____

What has happened to cause you to seek help NOW?_____

_____

_____

What do you hope to be able to do or achieve as a result of treatment?_____

_____

_____

What do you consider to be other stresses in your child's life?_____

_____

_____

HISTORY OF THE PROBLEM

When did you child first start experiencing the problem(s) that brought you to treatment?_____

_____

How often does the problem occur?_____

How long does it last?_____

Does your child have any thoughts of harming himself/herself?_____

Has your child ever attempted to harm him/herself? □N □Y If Yes, please explain:_____

_____

Does your child have any thoughts of harming someone else? □N □Y If Yes, please explain:___

_____

Has your child ever attempted to harm someone else? □N □Y If Yes, please explain:_____

_____

Has your child ever had previous therapy/counseling of any kind? □N □Y If yes, when and for how long?_____

_____

What concerns were addressed in therapy?_____

_____

Was this experience helpful (please explain)?_____

_____

Has your child ever had any psychological testing or nuero-psychological testing? □N □Y

If so, when?_____

_____

_____

Has you child ever been hospitalized for emotional/behavioral problems? □N □Y If yes, when/where was this?_____

_____

Has your child been prescribed medications for emotional/behavioral problem? □N □Y
If yes, please list medications, when prescribed, and by whom:

_____

_____

To your knowledge, has your child experimented with alcohol/drugs? □N □Y

Are you concerned that your child might have or be developing a problem with alcohol or drugs? □N □Y If yes, please explain:_____

_____

FAMILY

Has your child ever experienced any parental separations, divorces, or death? □N □Y

If yes, when? _____How old was the child at the time?_____

Please describe the circumstances: _____

_____

_____

If parents are separated or divorced, who has custody of the child? _____

How often does the other parent see this child? □ Weekly or more often □ Once or twice a month □ Few times a year □ Never

Please list the name, age, and sex for each sibling (including step-siblings, half-siblings, and those who may be deceased):

Name	Age	Sex	Relationship to Child	Living at home?
				□ No □Yes
				□ No □Yes
				□ No □Yes
				□ No □Yes
				□ No □Yes
				□ No □Yes

Other than any children already indicated above and parents, who else lives in the child's household?

_____

_____

Has anyone in the child's family had treatment for emotional problems? □N □Y

If yes, please explain (who/when): _____

_____

Has anyone in your family ever attempted or committed suicide? □N □Y

If yes, please explain (who/when):_____

_____

FAMILY HEALTH

Describe father's present health: _____

Describe mother's present health:_____

Has anyone in your immediate or extended family had emotional, psychiatric, or substance abuse problems? □N □Y
If yes, please explain_____

_____

What kinds of stressful events have your child experiences recently?_____

What kinds of stressful events have family members experienced recently?_____

CHILD'S EDUCATION

School (name, address)	Dates Attended	Grades attended	Teachers	Problems (Y/N)

If answered "yes" to problems at any academic level, please explain below. Provide information about any treatment provided by the school at the time of occurrence:

Is your child in any resource or special classes? □N □Y If yes, please describe:_____

Please describe your child's attitude towards school:

Has your child had any conduct or behavior problems in school? □N □Y If yes, please describe:

How would you rate your child's homework/study skills? (circle one) Good Average Poor
Describe any difficulties:

Has your child had tutoring? □N □Y If yes, please elaborate:

Does your child like to read? □N □Y How often:

Please rate reading ability: (circle one) Good Average Poor

Has your child ever had any educational testing? □N □Y If so, when?

TYPICAL DAY DESCRIPTIONS

On a school day, how does the child awaken? (eg: by himself, by you, etc…)

How does your child prepare himself for the day? (eg: who selects clothes, prepares backpack, etc…)

Does the child ready him/herself quickly or require continual reminding?

Does the child eat breakfast? □N □Y If yes, who prepares it?
What is a typical breakfast?

Does the child watch the time and leave promptly or is frequent reminding necessary?

To your knowledge, does the child eat lunch? □N □Y If so, who prepares it?
Any problems?

What does the child do after school?

What occurs at dinnertime?

Does the family eat together? □N □Y
Explain:
Is the child on time? □N □Y
Explain:
Are there any problems during dinner? □N □Y

Explain:_____
Does he/she participate in family conversations during the meal? □N □Y
Explain:_____

What occurs after dinner?_____

_____

What happens at bedtime?_____

_____

_____

What does the child do on weekends?
Friday evening:_____

Saturday:_____

Sunday:_____

Does your family have much "family time" together (eg: shopping, movies, games, etc…) □N □Y
Explain:_____

Does your child spend time with friends? □N □Y
How much time on a weekly basis?_____
How many friends does your child have?_____
How do you feel about your child's friends?_____

Does your child belong to any clubs, groups, organizations? □N □Y
If yes, which ones?_____

Does your child have any interests or hobbies? □N □Y
Explain:_____

_____

Does your child get an allowance? □N □Y
If yes, is it earned or given?_____

How does the child manage money?_____

_____

Does your child have specific chores? □N □Y
Please explain:_____

Does your child try to avoid doing chores? □N □Y

What does he/she do to try to avoid them?_____

_____

What methods do you use to discipline your child?_____

_____

How often is it necessary?_____
Does it work?_____

CHILD'S DEVELOPMENT

Was this a planned pregnancy? □N □Y

Was the mother under a doctor's care? □N □Y

Describe any complications that occurred during the pregnancy?_____

_____

_____

What drugs/medications were used during the pregnancy?_____

_____

Were there any problems during the delivery? □N □Y
If yes, please explain:_____

_____

Length of pregnancy:_____ Birth weight:_____lbs._____oz

Is this child adopted? □N □Y If yes, please provide adoption history:_____

_____

_____

Did the child's mother suffer from post-partum depression following this child or any other child's birth? □N □Y
If yes, please explain:_____

_____

Were there any stressful events that occurred in the family after this child's birth? □N □Y
If yes, please explain:_____

_____

Were there any feeding problems? □N □Y
If yes, please explain:_____

_____

Describe sleep patterns or problems:_____

_____

Language difficulties? □N □Y
If yes, please explain:_____

_____

At what age was your child toilet trained? _____ Were there any difficulties?_____

_____

At what age did your child:
_____Wean _____Walk _____Sit up along _____Talk

Were there any difficulties?_____

_____

Were any of the following present during the first few years?

Did not enjoy cuddling	□N □Y	Was not calmed by being held	□N □Y
Difficult to comfort	□N □Y	Colic	□N □Y
Excessive restlessness	□N □Y	Excessive irritability	□N □Y
Frequent head banging	□N □Y	Constantly into everything	□N □Y
Reflux	□N □Y	Listless/Unresponsive	□N □Y

As a young child, did your child have problems getting along with others? □N □Y
Explain:_____

_____

CHILD'S MEDICAL CARE

Child's Physician:_____ Phone Number:_____

Address:_____

Last Physical:_____

Current Medications and reason taking them:_____

_____

Does your child have any history of the following (please check all that apply):

□Hospitalizations □Surgeries □high fevers □Serious accidents

□Eye, ear, nose & throat problems □Digestive disorder □Head injuries

□Loss of consciousness □Headaches □Serious illness □Allergies

□Seizures

Please list below details of any conditions you checked above, including any additional childhood illnesses and other medical conditions:

Condition/Hospitalization	Age	Treated by Whom?	Outcome of Treatment

Please describe your child's strengths and positive characteristics:_____

_____

_____

_____

_____

LEGAL

Has anyone in your immediate family ever been arrested? If yes, explain.

Are you currently involved in any legal actions?

ANY OTHER INFORMATION IMPORTANT FOR ME TO KNOW?