# BECKY LENNOX

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## Child and Adolescent Mental Health Intake Form

***This intake form is for individuals' ages 3-17 years***
***It may be completed by the child, the parent and/or both***

**Legal Name:** **Preferred Name:**

**Gender Assigned at Birth:** **Pronouns: she/hers he/his they/them ze/zer ask me**

**Parent/Legal Guardian Name:**

**Legal shared parenting agreement? □Yes □ No** **Custody concerns? □Yes □No**

**For what issues are you seeking help?**

**When did these issues start?**

**What do you hope to gain from counseling? How will you know things are better?**

**How long do you expect to be in counseling?**
**□1-3 sessions □4-10 sessions □ A long time □No idea**

### Education

**School/Day Care Name:** ______________________________________________
**Current Grade:** ______ **Have an IEP or 504 Plan? □Yes □No**

**Any behavioral or academic concerns?** □**Yes** □**No**

## Developmental History

**Complications prior to birth?** □**Yes** □**No** **Complications at birth?** □**Yes** □**No**

**All developmental milestones met?** □**Yes** □**No**

**Any significant changes in life such as:**

□**Frequent moves** □**Changes in Caregivers** □**Death of a friend/relative**

□**Witness to violence** □**History of Abuse/Neglect** □**Other:**

**Work a part time job?** □Yes □No

**Involved in extra-curricular activities (sports, youth groups, or clubs)?** □Yes □No

**What do you like to do for fun?**

**Is spirituality a part of your life?** □Yes □No □It's complicated

## Family &Relationships

**Who lives in your home with you?**

**Do you have visits with another parent?** □ **Yes** □ **No** **If yes, how often do you visit?**

**Do you have siblings who live in another home?** □ **Yes** □ **No**

**Describe your relationship with family:**

**Are you dating?** □ **Yes** □ **No** **Are you currently in a relationship?** □ **Yes** □ **No**

**Describe your relationship with friends:**

**Do you feel supported by your friends and family?** □**Yes** □**No** □**Sometimes**

## Medical & Mental Health Treatment History

**Physician Name:** **Dentist Name:**

**Chronic medical problems** □**Yes** □**No** **Head Traumas/Concussions:** □**Yes** □**No**

**Past Counseling Experience?** □**Yes** □**No When?__________________ Where?__________________________**

**Please list any current medications:**

| Mental Health History | | | | | |
|---|---|---|---|---|---|
| | Self | Mother | Father | Sibling | Grandparent |
| Depression | □ | □ | □ | □ | □ |
| Anxiety | □ | □ | □ | □ | □ |
| Bipolar Disorder | □ | □ | □ | □ | □ |
| Schizophrenia | □ | □ | □ | □ | □ |
| Post-Traumatic Stress | □ | □ | □ | □ | □ |
| Drug/Alcohol Addiction | □ | □ | □ | □ | □ |
| Eating Disorder | □ | □ | □ | □ | □ |
| Violence | □ | □ | □ | □ | □ |
| Suicide | □ | □ | □ | □ | □ |
| Problems with Focus or Attention | □ | □ | □ | □ | □ |
| Other | □ | □ | □ | □ | □ |

| **Strengths & Difficulties** | | | |
|---|---|---|---|
| | **Not True** | **Somewhat True** | **True** |
| Considerate of other peoples' feelings | □ | □ | □ |
| Restless, overactive, cannot stay still for long | □ | □ | □ |
| Often complains of headaches, stomach-aches or sickness | □ | □ | □ |
| Shares readily with other youth | □ | □ | □ |
| Often loses temper | □ | □ | □ |
| Would rather be alone than with other youth | □ | □ | □ |
| Generally well behaved, usually complies with adult requests | □ | □ | □ |
| Many worries or often seems worried | □ | □ | □ |
| Helpful if someone is hurt, upset or feeling ill | □ | □ | □ |
| Constantly fidgeting or squirming | □ | □ | □ |
| Has at least one good friend | □ | □ | □ |
| Often fights with other youth or bullies them | □ | □ | □ |
| Often unhappy, depressed or tearful | □ | □ | □ |
| Generally liked by other youth | □ | □ | □ |
| Easily distracted, concentration wanders | □ | □ | □ |
| Nervous in new situations, easily loses confidence | □ | □ | □ |
| Kind to younger children | □ | □ | □ |
| Often lies or cheats | □ | □ | □ |
| Picked on or bullied by other youth | □ | □ | □ |
| Often offers to help others (parents, teachers, children) | □ | □ | □ |
| Thinks things through before acting | □ | □ | □ |
| Steals from home, school or elsewhere | □ | □ | □ |
| Gets along better with adults than with other youth | □ | □ | □ |
| Many fears, easily scared | □ | □ | □ |
| Good attention span, completes chores and/or homework | □ | □ | □ |

| **CURRENT SYMPTOMS CHECKLIST** | | | |
|---|---|---|---|
| ***Please check the appropriate box for symptoms you/your child have experienced in the past 2 weeks.*** | **Daily** √ | **Some** √ | **None** √ |
| Sadness/Depressed Mood/Crying Spells | | | |
| Temper Outbursts | | | |
| Withdrawn or Isolated | | | |
| Daydreaming | | | |
| Fearful | | | |
| Clumsy | | | |
| Over-reactive | | | |
| Short Attention Span/Difficulty Concentrating | | | |
| Fatigue/Low Energy | | | |
| Hard to make decisions | | | |
| Appetite increase or decrease/Feeding or eating problems | | | |
| Weight increase or decrease | | | |
| Distractible | | | |
| Suicidal thoughts | | | |
| Attempts to self -harm | | | |
| Peer Conflict/Mean to others | | | |
| Mood swings | | | |
| Increased energy | | | |
| Racing thoughts | | | |
| Bedwetting | | | |
| Decreased need for sleep | | | |
| Excessive worry | | | |
| Feeling "on edge" | | | |
| Panic Attacks | | | |
| Destructive | | | |
| Restlessness | | | |
| Irritability or Anger | | | |
| Stealing, lying, disregard for others | | | |
| Defiance toward authority | | | |
| Impulsivity | | | |
| Nightmares | | | |
| Hearing or seeing things - others don't see/hear | | | |

**Who completed this form:** □**Parent/Guardian** □**Client/Child** □ **Both Parent and Client**

______________________________________ ______________________________

**Parent/Guardian Signature** **Date** **Client/Child Signature** **Date**