Empower Psychological Services, PLLC
45200 Sterritt St. Ste 105
Utica, Mi., 48317
248-838-9227

Child-Adolescent Intake

Please provide the following information about your child:

Child's Full Name:	Nickname:
Birth Date:	Today's Date:
Child's Address:	Phone:
Parent(s) names or primary guardian:	Parent(s) contact numbers: Home: Cell: Work: Email Address:
In case of emergency, who may I contact on your behalf?	Name:
Phone number:	Relationship:

Education History

What school and District does your child attend:	Teacher's Name:
Current Grade:	Has your child ever repeated a grade? YES/ NO If so which one(s)_____
Favorite Subject:	Least Favorite Subject:
Does your child receive special education service? YES /NO	Does your child receive tutoring? YES/ NO
Is your child in a gifted/talented/honors program? YES/ NO	Does your child like school? YES/ NO

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Has your child experienced any of the following at school? (please circle all that apply) Fighting, suspension, lack of friends, gang influence, learning disabilities, incomplete homework, drug/alcohol, poor attendance, behavior problems, detention, poor grades
Has your child been the victim of bullying or bullied other children? YES/ NO. If yes, please describe:
Please, use the space to provide any other additional information regarding your child's education or developmental history that you find significant:

Medical History

Pediatrician's Name:	Phone:
Is child under the care of another medical specialist? YES/NO If yes, type of specialist: _____	Phone:

Please list any chronic illness, disabilities, medical conditions that your child has been diagnosed with:

Illness/Disability:	Dates:

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Please describe any history of:

Head Injuries:
Ear Infections:
Allergies:
Physical Handicaps:
Hearing or vision problems:
Sensory Problems (auditory, visual, tactile, smell/taste):
Sleep Difficulties:

List all medications that your child is currently taking:

Medication:	**Dosage:**	**Treating:**

Therapy / Psychiatric Experience

Is your child *currently* seeing another therapist? YES / NO			
If yes, who are you seeing?			
Has your child ever been in therapy in the past YES/ NO			
If yes, please fill out the following on your previous counseling experience(s)			
Therapist	Location	Dates	Reason

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Has your child ever had a psychiatric hospitalization? YES/ NO			
If yes describe briefly and indicate dates and circumstances			
Is your child under the care of a psychiatrist? YES/ NO		If yes, psychiatrist name:	
Phone:		Address:	

Developmental History

Problems at birth with your child:
Pregnancy and/or delivery Complications:
Length of Labor_____ Induced? YES/NO Caesarian? YES/NO Birth Weight_____ Birth Length_____
At what age did your child: Crawl_____ Walk_____ Babble_____ Toilet Train_____ Use first Words_____ Use Sentences_____ _____
Please circle the words that best describe your child's temperament: Easy to Soothe Hard to Soothe Irritable easy-going Distractible Shy Withdrawn anxious/nervous Consistent Inconsistent Sad Impulsive

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Family History

Mother's Name Occupation:		Father's Name: Occupation:	
Step-Mother?		Step Father?	
Who does your child currently live with?			
Names	Age	Relationship to child	Grade/Job
Who are your child's significant others NOT living with your child?			
Names	Age	Relationship to child	Grade/Job

Are child's parents'? Married Separated Divorced Widowed (please circle one) If parents divorced/separated please list dates:
Who in the family is your child closest too?

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What are some of the strengths of your family?
Does anyone in the child's family been diagnosed with a mental illness? YES/ NO If yes, please describe:
Is there anything else that you think would be important for me to know about your child, you, or your family?

Other History

Has your child ever experienced any type of abuse (physical, sexual, or emotional)? YES/ NO If yes, please describe:
Has your child ever made statement of wanting to him/her self or seriously hurt someone else? YES/ NO Has he/she purposely hurt himself or another? YES/ NO If yes, to either question please describe the situation:

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Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? YES/ NO. If yes, please explain:
Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets him/her in trouble? YES/NO. If yes, please describe:
Are there any behaviors that your child fails to do as often as you would like or when you would like?
Please list positive strengths of your child: (What do you like about your child? What do others like about your child?)
How would you describe your child's self-esteem? Briefly describe your reason(s) for seeking help at this time?
What goals do you wish to accomplish during the therapy process as a parent?

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What goals does your child wish to accomplish during the therapy process? (can be different than parent's response)

How were you referred to our office?