Dr. Andy Brown, LPC
Child/Adolescent Intake Form

CLIENT INFORMATION

Adolescent/Child's Last Name:	Adolescent/Child's First Name:
Date of Birth:	Age: Sex:
Mailing Address:	City/State/Zip:
Home Number:	Cell Phone:
School:	Grade:
Teacher:	Parent Email:
Who referred you to Dr. Andy Brown, LPC?	Other family members seen at Dr. Andy Brown, LPC?

BILLING INFORMATION

Person Responsible for payment:	Home Phone Number:
Mailing Address (if different):	City/State/Zip:
Primary Insurance Company:	Policy Number:
Date of Birth:	Client's Relationship to Party Responsible for Billing:

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Contact Number 1: Contact Number 2:
Relationship to the Client:	Additional Info:

The information above is accurate to the best of my knowledge. I authorize my insurance benefits be paid directly to the counselor providing services when applicable. I understand that I am ultimately financially responsible for any balance. I authorize Dr. Andy Brown, LPC or my insurance company to release any information required to process my claims.

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CLIENT'S/GUARDING SIGNATURE TODAY'S DATE

HISTORY

1. Has your child had prior counseling? If so, how long ago and with whom?

2. Is your child currently taking any medication? If so, please list the name of medication dosage.

3. Describe your child's current use of alcohol and/or drugs.

4. Do you have a family history of mental illness? If so, please explain.

5. Have you child ever been treated for substance abuse? If so, when, where, and for what substance(s).

6. Has your child ever attempted suicide or had a plan to harm yourself? When?

7. Does your child currently have any thoughts and feelings of wanting to physically harm his/her self? If so, please explain.

8. Has your child ever been diagnosed with an eating disorder? If so, explain.

9. Has your child ever been sexually abused or worry that he/she might have been?

10. Briefly describe any medical conditions that may be affecting your child's wellbeing.

11. Has your child's sleeping and/or eating habits changed within the last 3 months? If so, please explain.

12. Describe your child's current social functioning.

13. Describe your child's current academic/vocational functioning.

14. What are your goals for counseling?

SYMPTOM CHECKLIST

Please check any of the following that apply to your child.

	Headaches		Naïve		Memory problems
	Heart palpitations		Unattractive		Nervous
	Sleep problems		Fearful		Bored
	Wanting to hurt self		Timid		Restless
	Drug use		Poor concentration		Nightmares
	Financial problems		Worthwhile		Empty feelings
	Incompetent		Regrets for past		Fatigue
	Controlling		Misunderstood		Tense
	Shy		Sympathetic		Poor academic performance
	Don't take vacations		Intelligent		Worthless
	Confused		Fainting spell		Stupid
	Considerate		No appetite		Evil
	Disabled		Regular alcohol use		Over ambitious
	Not confident		Depressed		Good person
	Cannot make decisions		Inadequate		Dizziness
	Few friends		Disturbing thoughts		Attractive
	Stomach problems		Guilty		Lonely
	Feelings of panic		Hateful		Not loved
	Trembling		Inferior		Confident
	Unable to relax		Bad home environment		Cannot keep a job

Please add any additional information on the reverse side of this document.