# Moosilauke Counseling Solutions Child and Adolescent Intake Form

Date: _____

Name of Person Completing Form: _____

Relationship to Child: _____

## Demographic Information

Child's Name (First, MI, Last): _____

Preferred Name or Nickname: _____

Date of Birth: _____

Age: _____

Biological Sex: _____

Preferred Sex: _____

Mailing Address: _____

Physical Address (if different from above): _____

**Please DO NOT list any numbers where you do not want to receive calls and/or messages**

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

What is the best way for us to reach you (phone or email): _____

Child's Legal Guardian(s) Names: _____

Child's Legal Guardian(s) Numbers: _____

Parents/Guardians Names (if different from above): _____

Parents/Guardians Numbers (if different from above): _____

* Please note that we require a copy of court documents regarding custody/guardianship/decision-making rights in circumstances where alternate arrangements have been ordered.

*It is our policy to receive consent for treatment from guardian(s) at the time of treatment. If additional legal guardians have questions or object to treatment, it is the responsibility of those seeking treatment to provide documentation at the time of treatment.

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Preferred Phone Number: _____

Preferred Hospital Name: _____

Preferred Hospital Number: _____

## Insurance Information

Primary Insurance Company: _____

ID Number: _____

Group Number: _____

Secondary Insurance Company: _____

ID Number: _____

Group Number: _____

## Medical History

Child's Primary Care Provider Name: _____

Child's Primary Care Provider Number: _____

Allergies: _____

Child's Current Medications (name, reason, and prescribing provider):

_____

_____

_____

Child's Current Medical Issues:

_____

_____

_____

Has your child ever had any of the following health issues:

Seizures or convulsions Yes _____ No _____

Head injury (specify if with or without loss of consciousness) Yes _____ No _____

If yes please list date: _____

Asthma Yes_____ No_____

Heart Condition (including murmurs) Yes _____ No _____

If yes, please list condition: _____

Serious infection or injury Yes _____ No_____

If yes, please describe: _____

Surgery Yes _____ No _____

If yes, please describe: _____

## Developmental History

Was your child born at term? Yes _____ No _____

If no, please specify gestational age at birth: _____

Was your child born via vaginal or caesarian section: _____

Were there any complications during pregnancy or delivery: _____

_____

Was your child exposed to any illness(es) or substance(s) during pregnancy? Yes _____ No ____

If yes, please specify what illness(es) and/or substance(s): _____

Did your child meet their developmental milestones? Yes _____ No _____

If no, please specify what delays were present: _____

Does your child have any known genetic conditions? Yes _____ No _____

If yes, please specify what genetic conditions: _____

## Psychiatric History

Does your child currently see a psychotherapist? Yes_____ No _____

Current Psychotherapist Name: _____

Current Psychotherapist Number: _____

Has your child ever seen a psychotherapist Yes _____ No _____

Former Psychotherapist Name: _____

Former Psychotherapist Number: _____

Past psychotherapy treatment approaches tried (CBT, DBT, etc.…): _____

_____

Is your child currently taking any medication for a psychiatric reason? Yes____ No ____

If yes, please list name, dosage, frequency, start date of medications, and prescribing provider:

_____

_____

Has your child ever taken medication for a psychiatric reason? Yes _____ No _____

If yes, please list name and reason for discontinuing: _____

_____

Has your child ever been hospitalized for a psychiatric reason? Yes _____ No _____

If yes, please list hospital and reason for hospitalization: _____

_____

**Family History**

Please list any known medical and psychiatric history within your family (including extended family):

_____

_____

**Education/Schooling**

What grade is your child currently in: _____

What school does your child currently attend: _____

Name of your child's primary teacher (if applicable): _____

Name of your child's school counselor(s): _____

Has your child ever repeated a grade in school? Yes _____ No _____ If yes, what grade: _____

Does or has your child ever received special education services through an IEP or a 504B plan?

Yes _____ No_____

Has your child ever received psychoeducational testing? Yes _____ No _____

If yes, when, and where did psychoeducational testing occur: _____

**If your child has an IEP or has received psychoeducational testing, please bring with them to their appointment.**

## Treatment

In a sentence or two, please tell us your reason(s) for seeking help for your child: _____

_____

_____

Please tell us what you hope to gain from treatment for your child: _____

_____

_____

Please tell us if you are looking for any specific treatment approaches: _____

_____

_____

Please tell us any fears you have about seeking help: _____

_____

_____

Anything else you think we should know about your child: _____

_____

_____

Are you looking for in-person or telehealth appointments? _____

What is your availability? _____