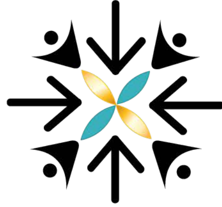

THE
INTENTIONAL WELLNESS
Wellness With Intent
GROUP

Adolescent/Child Intake Form

Today's Date ____________________

Client Name: ____

Date of Birth: ______________________ Age: __________ ☐ Male ☐ Female

Diagnosis (if known): ____________________________________

Address: ____

City, State, Zip: ____

Home Tel: _________________________ Cell#: ______________________________

Email: ____

Religious Affiliation: ____________________________________

Referred by: ____

Family Background

Mother's Name: __________________________ Step-Mother's Name: ____________________________

Date of Birth: ________________ Age: _______ Phone#: ________________________________

Occupation: ____________________________ Education Level: ________________________________

Father's Name: __________________________ Step-Father's Name: ____________________________

Date of Birth: _________________ Age: _______ Phone#: ________________________________

Occupation: ____________________________ Education Level: ________________________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

What adults does the child live with? Check all that apply:

☐Birth Parent(s) ☐Adoptive Parent(s) ☐Foster Parent(s)

☐Grandparent(s) ☐Both Parents ☐Mother Only

☐Father Only ☐Other: ____

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Other Family in the Home

Name	Age	Gender	Relationship
______________________	____	☐ Male ☐ Female	______________
______________________	____	☐ Male ☐ Female	______________
______________________	____	☐ Male ☐ Female	______________
______________________	____	☐ Male ☐ Female	______________

Is there anything additional you would like to share about the family / home environment?

____

Education

School: ______________________ Grade: ______________________

School Counselor: ______________________ School Phone#: ______________________

Type of classroom: ____

If they receive any accommodations, please describe: ______________________

____

Please describe any educational difficulties or learning challenges that this child has faced:

____

____

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service (OT, TSS, Speech, etc)

____

____

Medical History

Primary Care Physician: ____

Physician Phone Number: ____

Physician Address: ____

Other Physicians / Specialists Involved In Care:

Referring Physician: ______________________ Phone #: ______________________

Physician Address: ____

Secondary Physician: ______________________ Phone #: ______________________

Physician Address: ____

Describe any pertinent medical history (surgeries, diagnoses, hospitalizations, etc.) as well as when they were diagnosed and by whom:

____

____

Mother's Health During Pregnancy:

1. Were there any illnesses? ☐Yes ☐No
Describe: ____________________

2. Was there any stress during the pregnancy? ☐Yes ☐No
Describe: ____________________

3. Were there any complications during labor or delivery? ☐Yes ☐No
Describe: ____________________

Child's Development After Birth ☐Delayed ☐Normal ☐Advanced

Is the child currently on any medications? If so, please list medication name and reason for medication:
Medication 1: ____________________
Medication 2: ____________________
Medication 3: ____________________
Medication 4: ____________________

Does the child have any known allergies? ☐Yes ☐No
Describe: ____________________
Describe the child's current health status: ____________________

____

Mental Health & Social History

Have you ever had a previous counseling or mental health treatment (Hospitalization/Inpatient)?

☐Yes ☐ No

By whom: ____________________ When: ____________________

Describe the results:

____

____

Are you currently working with another provider? ☐Yes ☐No

Provider Name: ____________________

Contact Information: ____________________

Does anyone in your family have a history of mental health concerns or diagnosis or substance abuse history? ____________________

____

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Describe how the child interacts with parents, siblings, or other family members:

What are the child's strengths?

What are the child's weaknesses?

What are the child's favorite activities?

Insurance Information

Insurance Company: ______________________ I.D.#: ______________

Employer: ______________________ Group#: ______________

Emergency Contact

Contact Name: ______________________

Relationship to Child: ______________________

Emergency Contact Phone/Address: ______________________

Person filling out the form: ______________________

Relationship to the child: ______________________

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