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**CHILD AND ADOLESCENT  
INTAKE INFORMATION**

**PLEASE BRING THIS WITH YOU TO YOUR FIRST APPOINTMENT**

**Directions:** Please answer the following questions. **Please COMMENT** about any item you check as a problem area, and state whether it is a past or present concern. Feel free to contact me if you have questions or need assistance.

**Your name and relationship to child:** \_\_\_\_\_

1. Child's Name: \_\_\_\_\_  
Grade: \_\_\_\_\_ School: \_\_\_\_\_  
\_\_\_ Male \_\_\_ Female DOB: \_\_\_\_\_ Age: \_\_\_\_\_

2. **Presenting Problem** (Please list your concerns)

How often do the behaviors occur?

How long you have been concerned?

What has helped in the past?

**How will you know that the problems that brought you and your family here are resolved?**

**What has gotten better since you decided to call me?**

3. **Family:**

**Agencies/services providers with which client/family are currently involved:**

- Department of Human Services (DHS) (Formerly Services to Children and Families, SCF, CSD)
- Mental Health/A&D Provider
- Juvenile Department  Medical Provider
- Oregon Youth Authority  Other (please list Agency below):
- Mental Retardation/Developmental Disabilities Department

**Comments:**

**Who has custody of your child?**

- Custody of Parent(s)
- Custody of Guardian
- Supervision by Juvenile Court
- Custody of SCF
- Oregon Youth Authority

**Comments:**

**Has either parent had legal/police involvement?**  Yes  No

**Comments:**

**Family Configuration:**

Parents names	Ages		Siblings names	Ages
Others living in home:				

Other relatives/friends involved	Ages	Relationship

**Family Work History:**

Name	Job Title/Employer	Date of Employment

Other sources of Income (SSI, AFS, etc):

**4. Previous Counseling:**

**Has your child been in counseling before?**

- Mental Health Treatment  Day Treatment
- Outpatient  Residential Treatment
- Inpatient  Partial Hospitalization

**Agency/Counselor Name:**

**Comments:** (indicate counselor and agency name, seen when and for how long)

**Has your child ever expressed thoughts of hurting or killing him/herself?:**  Yes  No

**Prior Attempts to kill him/herself:**  Yes  No

**Comments:**

Has anyone in the family been in counseling before? (or experienced depression, ADHD, anxiety, schizophrenia?) \_\_\_\_\_ Yes \_\_\_\_\_ No

Comments:

**5. Drug/Alcohol History**

**Client Drug or Alcohol Use (alcohol, tobacco, street and prescription drugs):**

Do you know/suspect your child is using drugs, tobacco, or alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has your child ever used drugs, tobacco, or alcohol? | \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes:

a. Substance Used: \_\_\_\_\_

b. Amount of use of each substance: \_\_\_\_\_

c. Length of Use of each substance: \_\_\_\_\_

d. Last date of use of each substance: \_\_\_\_\_

e. Withdrawal symptoms: \_\_\_ delirium tremens \_\_\_ anxiety \_\_\_ sleep loss \_\_\_ shakes \_\_\_ tremors  
\_\_\_ disorientation \_\_\_ nausea \_\_\_ vomiting \_\_\_ headaches \_\_\_ other \_\_\_\_\_

f. Associated consequences of use: \_\_\_ academic decline/failure, \_\_\_ legal problems \_\_\_ DUIs \_\_\_ school suspension/expulsion  
\_\_\_ relationship problems \_\_\_ aggressive behavior  
\_\_\_ other \_\_\_\_\_

g. Current and/or previous chemical dependency treatment:

1. inpatient/outpatient (date(s) and length of treatment and where treated) \_\_\_\_\_

2. involvement in 12 step program(s) \_\_\_\_\_

h. Do you consider your child's use to be a problem? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, would you like your child to receive a chemical dependency evaluation? \_\_\_\_\_ Yes \_\_\_\_\_ No

Comments:

**Family Drug/Alcohol Use (Past or Present):** \_\_\_\_\_ Yes \_\_\_\_\_ No

**If yes:**

a. Substances used: \_\_\_\_\_

b. Date of last use: \_\_\_\_\_

c. Do you consider your or your family's use to be a problem for your child? \_\_\_\_\_ Yes \_\_\_\_\_ No

Comments:

**6. Developmental/Nutritional History:** Please Check and **COMMENT** if Problem Area

\_\_\_\_ 1. Pregnancy Difficulties/Abnormalities

\_\_\_\_ 10. Night Terrors

\_\_\_\_ 2. Alcohol Or Street Drug Use During Pregnancy

\_\_\_\_ 11. Walking/Gross Motor Problems

\_\_\_\_ 3. Medication Used During Pregnancy

\_\_\_\_ 12. Hand Coordination/Fine Motor Problems

- \_\_\_ 4. Difficulties During Delivery
- \_\_\_ 5. Did Not Meet Developmental Milestones
- \_\_\_ 6. Problems Eating As A Baby
- \_\_\_ 7. Exposure To Lead
- \_\_\_ 8. Eating Non-Foods
- \_\_\_ 9. Problems Sleeping As A Baby

- \_\_\_ 13. Speech/Language Problems
- \_\_\_ 14. Excessive Fears
- \_\_\_ 15. Overly Social/Friendly
- \_\_\_ 16. Poor Attachment To Parents/Caregivers
- \_\_\_ 17. Away From Parents For A Long Time
- \_\_\_ 18. Difficult To Comfort

Weight at Birth: \_\_\_\_\_  
 Age sitting up alone? \_\_\_\_\_  
 Age standing alone? \_\_\_\_\_  
 Age using single words? \_\_\_\_\_  
 Age Potty Trained? \_\_\_\_\_

Age Crawling? \_\_\_\_\_  
 Age Walking? \_\_\_\_\_  
 Age using sentences? \_\_\_\_\_

**Comments on each # checked:**

**7. Medical/Physical History**

Please Check and **COMMENT** if Problem Area

- \_\_\_ 19. Allergies
- \_\_\_ 20. Asthma
- \_\_\_ 21. Headaches
- \_\_\_ 22. Head Injury/Trauma
- \_\_\_ 23. Seizures
- \_\_\_ 24. Accidents/Major Injuries
- \_\_\_ 25. Chronic Illness/Disease
- \_\_\_ 26. Surgeries
- \_\_\_ 27. Hospitalizations
- \_\_\_ 28. Pregnancies

- \_\_\_ 29. Current Sleeping Problems
- \_\_\_ 30. Enuresis (urinary accidents)
- \_\_\_ 31. Encopresis (bowel accidents)
- \_\_\_ 32. Overactive/Hyperactive
- \_\_\_ 33. Lack of Energy
- \_\_\_ 34. Vision Problems
- \_\_\_ 35. Hearing Problems
- \_\_\_ 36. Recurring Infections
- \_\_\_ 37. Medications
- \_\_\_ 38. Muscle jerks/twitches/tics
- \_\_\_ 39. Current Eating Problems

**Comments on each # checked:**

**8. Education/Vocational History**

Please Check and **COMMENT** if Problem Area

- \_\_\_ 40. Low Grades
- \_\_\_ 41. Failing Grades
- \_\_\_ 42. Underachievement
- \_\_\_ 43. Overachievement
- \_\_\_ 44. Learning Disability

- \_\_\_ 45. Suspensions/Expulsions
- \_\_\_ 46. Alternative School Classroom
- \_\_\_ 47. Social/Behavioral Problems
- \_\_\_ 48. IEP(Individualized Education Plan)
- \_\_\_ 49. Day care/babysitter history
- \_\_\_ 50. Skipping/Poor attendance

**Comments on each # checked:**

List the schools your child has attended:

**9. Social/Community History:**

Please Check and **COMMENT** if Problem Area

- \_\_\_ 51. Unable to Keep Friends
- \_\_\_ 52. Likes to be Alone
- \_\_\_ 53. Argumentative
- \_\_\_ 54. Acts Young for Age
- \_\_\_ 55. Aggressive/Assaultive Behavior

- \_\_\_ 61. Firesetting
- \_\_\_ 62. Homicidal Ideation/Threats of killing others
- \_\_\_ 63. Vandalism/Destructive
- \_\_\_ 64. Gang Interest/Involved
- \_\_\_ 65. Arrests

- |  |  |
|--|--|
| <input type="checkbox"/> 56. Self Abusive Behaviors                              | <input type="checkbox"/> 66. Sexuality Concerns                  |
| <input type="checkbox"/> 57. Lying(excessive, more than avoidance of discipline) | <input type="checkbox"/> 67. Sexual Acting Out/Offending         |
| <input type="checkbox"/> 58. Running Away  | <input type="checkbox"/> 68. Exposure to Weapons                 |
| <input type="checkbox"/> 59. Stealing  | <input type="checkbox"/> 69. Hurts Animals                       |
| <input type="checkbox"/> 60. Repetitive habits/obsessive habits                  | <input type="checkbox"/> 70. Depression/excessive crying/sadness |

**Comments on each # checked:**

**10. Environmental/Trauma History**

Please Check and **COMMENT** if Problem Area

- |  |  |
|--|--|
| <input type="checkbox"/> 71. Homelessness                    | <input type="checkbox"/> 78. Emotional Abuse           |
| <input type="checkbox"/> 72. Domestic Violence               | <input type="checkbox"/> 79. Sexual Abuse              |
| <input type="checkbox"/> 73. Witnessed Violence in Community | <input type="checkbox"/> 80. Physical Abuse            |
| <input type="checkbox"/> 74. Financial Stress                | <input type="checkbox"/> 81. Frequent Moves            |
| <input type="checkbox"/> 75. Natural Disasters/Accidents     | <input type="checkbox"/> 82. Death in family/friends   |
| <input type="checkbox"/> 76. Neglect                         | <input type="checkbox"/> 83. Divorce in family/friends |
| <input type="checkbox"/> 77. Out of home placement           | <input type="checkbox"/> 84. Other                     |

**Comments on each # checked:**

**11. Cultural History/Religious Affiliation** (please note ethnicity, family values, language spoken by family, what religion is practiced, church attendance, ethnic social supports, and whether social pressures due to ethnicity play a part in child's presenting problems):

**12. Have you or anyone else ever been concerned about the child's sexual behavior?**

Yes  No      If yes, what was the behavior and who was concerned:

**13. Family/Client Strengths:**

**What are the best qualities/strengths of your child?**

**What are the best qualities/strengths of your family?**

**What are the best qualities/strengths of you as a parent?**

**Discipline Strategies:**

**What discipline do you use that works?**

**What discipline have you tried that doesn't work?**

**Media History:** Please check all that apply:

TV in home \_\_\_\_\_

Video Games in home \_\_\_\_\_

TV in child's bedroom \_\_\_\_\_

Video Games in child's bedroom \_\_\_\_\_

# hours TV watched by child per day? \_\_\_\_\_

# hours video games played by child per day?

\_\_\_\_\_  
Child's favorite type of TV show/movies/video games?

**Other Comments/Concerns:**

**This intake information has been filled out accurately and completely to the best of my knowledge.**

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_