Anchor & Balance Restorative Services, LLC
Sarah B. Michalowski, DSW, LCSW
Telehealth
drsarah@anchorandbalance.com
551-333-9679 (google voice)

Child and Adolescent Intake Form

Please provide the following information. Please note this information will be kept confidential

Demographic Information

Date: _____

Client's Name: _____
(Last) (First)

DOB: _____ Age: _____ Gender: _____

Ethnicity: _____ Religious Background: _____

Birthplace: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Name of parent(s)/guardian(s) who have legal custody of child:

_____

* *Address if parent/guardian lives in another residence:*
Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ *Is it ok to leave a voicemail?* *YES* *NO*

Cell Phone: _____ *Is it ok to leave a voicemail?* *YES* *NO*

Email: _____
Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

Referred by: _____
(Name) (Relationship)

Is it okay to send the referral source a "thank you"? *YES* *NO*
If Yes, Referral contact information:

_____
(Address) (Email) (Phone)

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How Have We Come to Meet?

What are the 3 biggest concerns or symptoms you have for your child right now for which you are seeking services (i.e. significant life changes, stressful events or losses, etc.)? How long have each been going one? Please list them in order of importance:

1. _____
2. _____
3. _____

What do you think your child would say their biggest concern(s) is/are?

_____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____

Have you or your child(ren) had therapy in the past? If so, please provide treatment providers names, dates of service, what your child was seen for, and results. What was helpful? What was not helpful?

Change is Coming…

What are your expectations/goals from therapy? What are your expectations of the therapist?

List concrete changes you would like to see happen during the course of therapy:

What other things would you like to see change in your life and your family's life?

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_____
_____
_____

Do you foresee any obstacles to achieving your goals or the desired changes for your child?

_____
_____
_____
_____
_____
_____
_____

How long do you think therapy will need to last to achieve the changes/goals you want for your child? Write down a target date:

_____

List 5 strengths about your child, give examples of each:

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

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Medical Background

Has your child ever received psychiatric services before (including hospitalizations)? YES NO
If yes, how long ago, with whom, for what, and results:

_____
_____
_____

Many parents have opinions on psychiatric medications, what are yours?

_____
_____
_____

Does your child have any allergies (food, environmental, medicinal, animal, etc.)

_____
_____
_____

Does your child have any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what?

_____
_____
_____

Is your child presently under a physician's care? If so, for what?

_____
_____
_____

List medications (over the counter & prescribed), nutritional or herbal supplements, alternative treatments (acupuncture, chiropractic, etc.) your child is taking/doing and reasons:

_____
_____
_____

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Developmental History

What was the pregnancy of your child like (full term, preemie, type of labor, any complications during pregnancy or at birth, environment and situations during pregnancy and birth).

_____

_____

Did the mother take medications taken during pregnancy? If so, what type.

_____

During pregnancy, did the mother:
Smoke cigarettes? _____ Drink alcohol? _____ Take drugs? _____

What was the child's birth weight? _____

Please describe your child's development milestones (delayed, on time, early) (i.e. rolling, sitting up, babbling, walking, eating, toilet training).

_____

_____

_____

Please describe your child's temperament.

_____

_____

_____

Important Questions I Must Ask

Has your child ever had thoughts that s/he did not want to live? YES NO
If yes, please explain:

_____

_____

Does your child currently feel that s/he does not want to live? YES NO
If yes, please explain (i.e. how often do you have the thought, when was the last time you had the thought, did something happen to make you have the thought, would anything make it better):

_____

_____

_____

_____

Has your child ever had thoughts of killing themselves? YES NO
If yes, please explain (is the method readily available):

_____

_____

Has your child ever planned on killing themselves? YES NO
If yes, please explain:

_____

_____

Has your child ever attempted to kill themselves? YES NO
If yes, please explain:

_____

_____

Has anyone in your family or close to you died by suicide? YES NO
If yes, please explain:

_____

_____

Has your child ever felt like they wanted to seriously hurt or kill someone else?
If yes, please explain: YES NO

_____

_____

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

_____

_____

Does your child have a history of or currently engage in self harm? YES NO
If yes, please explain (current or past and with what/how):

_____

_____

Is there any past or present abuse (sexual, physical, emotional, neglect) or violence? YES NO
If so, please explain (including DCP&P involvement):

_____

_____

Has your child ever witnessed or experienced a trauma? Does your child have reoccurring nightmares, flashbacks, or avoid anything that is uncomfortable or painful? If so, please explain:

_____
_____
_____

Does your child have a history of substance abuse (alcohol or drugs)? If so, please explain:

_____
_____

Is your child currently using any illegal drugs or is the reason you are seeking therapy services substance related?

_____
_____

Are you concerned your child may see or hear things that do not appear to be real? If so, please explain:

_____
_____

Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put them at risk? Or is the reason you are seeking therapy related to a court order? If so, please explain?

_____
_____

Do you have any concerns about your child's sexuality, gender or sexual development?

_____
_____

Education, Responsibility, Recreation and Leisure

What school does your child attend? _____

What grade is your child in? _____

How are your child's grades? _____

Has your child ever been held back or receive specialized academic services (IEP)? If so, for what?

What concerns, if any, do you have about your child's education or schooling (grades, peers, relationships with teachers, behavior, etc)?

_____

_____

What is your child's relationship like with his/her peers?

_____

_____

What would your child say they like and dislike about school:
Likes: _____
Dislikes: _____

What hobbies or extra-curricular activities does your child engage in?

_____

_____

What responsibilities does your child have at home?

_____

_____

If your child is age 14 yr. and above what skills do you think your child needs to be independent? How are they learning them? What else do they need to gain independence?

_____

_____

What other responsibilities or skills would you like to see your child have/achieve?

_____

_____

Does your child have their own cell phone? YES NO

What are the rules around your child's cell phone use? Who enforces those rules?

_____

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Understanding Your Family

** Space left for therapist to draw family tree (genogram)*

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

Who lives in the home with the child?

_____

_____

If parents are not together who lives in the other house with the child?

_____

_____

If one or both parents are absent, if so for how long and reason for absences:

_____

_____

If parents are not together please describe the parents' relationship with one another:

_____

_____

Does your family have any pets? If yes, names, types and relationship to each pet:

_____

_____

- CONTINUED ON NEXT PAGE -

List 5 or more strengths of your family:

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

Is there anything that gets in the way of your family being the way you want it to be?

_____
_____

Name, relationship and description of relationship's that your child has with each family member:

Parent 1:

_____

Parent 2:

_____

Step-parents or parent's significant other:

_____

Siblings: Age, Name and Sex:

a. Sibling 1
   _____
b. Sibling 2
   _____
c. Sibling 3
   _____
d. Sibling 4
   _____

Other important relationships:

_____
_____

Does your family belong to any religious or spiritual groups? YES NO
If yes, what is your level of involvement?

_____
_____

Who else do you consider to be part of or supportive to your family (people or affiliations):

_____
_____

Please list anything else that you think is important for me to know about your child that would assist me in working with you and your child to achieve your desired results:

_____
_____
_____
_____
_____
_____
_____
_____
_____

- Thank You –

_____ _____
Clinician, Credentials Date

