



WATERSHED

COUNSELING AND CONSULTING

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Confidential Information – Child /Adolescent Intake

(Please Print and use black ink)

Name of Child _____ Sex: M ___ F ___ Date of Assessment _____

Date of Birth _____ Age: years _____ months _____ Grade _____ School _____

Name of Parent _____ Cell phone: _____ Work phone: _____

Home Address _____
Street _____ City _____ State _____ Zip _____

Parent's Email Address _____

Current Family Situation:

Mother's Relationship to child: ___ Natural parent ___ Step-parent ___ Adoptive parent ___ Relative

Age _____ Education _____ Occupation _____ Employer _____

Father's Relationship to child: ___ Natural parent ___ Step-parent ___ Adoptive parent ___ Relative

Age _____ Education _____ Occupation _____ Employer _____

Marital History of Parents: Natural Parents: ___ married / when _____
___ separated/ when _____
___ divorced/ when _____
___ deceased/ M/F _____
Step-Parents: ___ married / when _____
___ separated/when _____
___ divorced/ when _____
___ deceased/ M/F _____

If Child is Adopted:

Adoption Source _____ Age of child at adoption _____ Date of adoption _____

Reason and circumstances _____

What has the child been told about his/her adoption? _____

Living Arrangements:

Other Family Members: Place a check mark beside the name(s) of those with whom the child now lives. Circle (M)ale or (F)emale

Siblings _____ Age _____ M/F Parents _____ M/F Grandparents _____ M/F
_____ Age _____ M/F _____ M/F _____ M/F
_____ Age _____ M/F _____ M/F _____ M/F
_____ Age _____ M/F _____ M/F _____ M/F
_____ Age _____ M/F _____ M/F _____ M/F
_____ Age _____ M/F _____ M/F _____ M/F
Others living in the home and relationship _____ M/F

Medical Information:

Normal Pregnancy with child: YES ___ NO ___ If no, please explain: _____

Full Term: YES ___ NO ___ If no, please explain: _____

Birth weight: ___ lbs. ___ oz. **Type of delivery:** _____ **Any complications?** _____

Family Physician / Pediatrician / Psychiatrist / Etc. (Doctor(s) seen routinely):

[1] Name _____ Phone _____ Years seen _____

Address_____ City _____ State _____ Zip _____

[2] Name _____ Phone _____ Years seen _____

Address_____ City _____ State _____ Zip _____

Does the child have any current or ongoing medical problems, symptoms, hospitalizations? Please explain: _____

Current Medications: Taken as prescribed?

Medication	Dosage	Yes	No	Doctor	Reason	How Long?
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			

Previous Mental Health Services:

Type of Services	Provider	Date of Services

Other Information:

Current or expected legal involvement? Yes No Current Order of Protection or Restraining Order? Yes No

If yes, please explain: _____

Referred by: _____ Friend / Doctor / Therapist / Agency / Church Phone: _____

May I have your permission to thank this person for their referral? Yes No Initials: _____

Person(s) to notify in case of any emergency: _____ Relationship: _____ Phone: _____

Please provide your signature to indicate that I may contact them, if needed. (Your Signature): _____

Religious affiliation: _____ Frequency of involvement/activities _____

Child's current level of satisfaction with friends and social support: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent) Circle level

What do you consider to be your child's strengths? _____

Briefly describe the problems and reasons that brought you here: _____

What would you like to achieve and/or see happen by coming here for care? _____