

Kathryn H. Hedican LMHC, RPT, LLC
Intake
Basic Information

Date: _____
Client's Name: _____ DOB: _____ Age: _____
Parent(s) providing information: _____
Referral Source: _____

Presenting Problem and Symptoms:

To what extent have these problems disrupted your child's school life in the last month?

Not at all Mildly Moderately Mostly Extremely
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

To what extent have these problems disrupted your child's life with family and friends in the last month?

Not at all Mildly Moderately Mostly Extremely
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

To what extent have these problems disrupted your family's life in the last month?

Not at all Mildly Moderately Mostly Extremely
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Which of these relate to your child?

- | | | |
|---|--|---|
| <input type="checkbox"/> withdrawn | <input type="checkbox"/> depressed | <input type="checkbox"/> feelings of hopelessness |
| <input type="checkbox"/> increased aggression | <input type="checkbox"/> irritable | <input type="checkbox"/> school difficulties |
| <input type="checkbox"/> crying spells | <input type="checkbox"/> bedwetting | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> anger outbursts | <input type="checkbox"/> oppositional | <input type="checkbox"/> non-compliant |
| <input type="checkbox"/> physical abuse issues | <input type="checkbox"/> sexual abuse issues | <input type="checkbox"/> interested in fire setting |
| <input type="checkbox"/> change in friends | <input type="checkbox"/> obsessions | <input type="checkbox"/> perfectionistic tendencies |
| <input type="checkbox"/> hyperactive | <input type="checkbox"/> decreased energy/motivation | |
| <input type="checkbox"/> thoughts of hurting self | <input type="checkbox"/> thoughts of hurting others | |
| <input type="checkbox"/> other: _____ | | |

Mental Health Treatment History

Agency/Hospital Dates Treatment Received and Outcome

Developmental History

1. How was the mother’s health during pregnancy and birth?

2. Were there any complications during birth?

3. Was the child born prematurely? If so, how early? _____

4. Have you or any other adults had any concerns about your child’s development in any of the following areas?

	Y	N
Speech and language development	_____	_____
Hearing	_____	_____
Vision	_____	_____
Intelligence/ability to learn	_____	_____
Bladder/bowel control	_____	_____
Emotional maturity	_____	_____
Social skills	_____	_____
Eating Habits	_____	_____
Fine motor skills (write, color, etc.)	_____	_____
Gross motor skills (walk, run, etc.)	_____	_____

Medical History

1. Primary Care Clinic: _____ Doctor: _____

2. Past hospitalizations, surgeries, medical issues:

3. Medication:

4. Current Psychiatrist:

5. Family history of medical problems (mental health, suicide, learning disabilities, substance abuse, etc.):
