

**Progressive Counseling & Consulting, LLC**

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CHILD INTAKE ASSESSMENT

*(Please print all information)*

HOME PH.: \_\_\_\_\_

WORK PH.: \_\_\_\_\_

CELL PH.: \_\_\_\_\_

**I. Child Client**

Today's Date: \_\_\_\_\_

A. Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

How does parent prefer to be contacted? Home Work Cell Email

Other \_\_\_\_\_

B. What are the concerns about your child for which you are seeking assistance?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**II. Family Information**

A. Race/Cultural Information:

1. Race: \_\_\_\_\_

2. Cultural Considerations: \_\_\_\_\_

B. Family History of Mental Health or Substance Abuse Problems:

[ ] NO [ ] YES Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Child's Parents  Married  Divorced  Separated  Never Married

Birth Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_

If Deceased, Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Highest Grade Level: \_\_\_\_\_

Step Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_

If Deceased, Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Highest Grade Level: \_\_\_\_\_

Adopted Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_

If Deceased, Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Highest Grade Level: \_\_\_\_\_

D. Annual Family Income:  Under \$30,000  \$31,000-\$60,000

\$91,000  \$121,000-\$150,000  Over \$151,000

E. Language Spoken: \_\_\_\_\_

F. Family Size: \_\_\_\_\_

G. Client's Brothers and Sisters

Name	Age	Occupation	Education	If Deceased, Date & Cause	Biological, Adopted, or Step

H. Other Household Members:

Name	Age	Sex	Occupation or Grade	Relationship to Client

I. Relationships

1. Who does your child live with currently? \_\_\_\_\_

2. Who did your child live with previously? \_\_\_\_\_

3. Describe your child's relationship with:

Parents: \_\_\_\_\_

Siblings: \_\_\_\_\_

Extended Family Members: \_\_\_\_\_

Teacher(s): \_\_\_\_\_

Other Children: \_\_\_\_\_

4. List any family members you wish to have involved in treatment and why:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. Therapeutic History

A. Has your child ever been to counseling for any reason in the past? Yes No

If so, why? \_\_\_\_\_

\_\_\_\_\_

How long was he/she in counseling? \_\_\_\_\_

Counselor's Name: \_\_\_\_\_

B. Is he/she currently seeing a counselor/psychologist/psychiatrist? Yes No

If so, why? \_\_\_\_\_

\_\_\_\_\_

How long has he/she been in counseling? \_\_\_\_\_

Counselor's Name: \_\_\_\_\_

**IV. Physical Description**

A. Child's Height \_\_\_\_\_ Weight \_\_\_\_\_ Recent Gains/Losses \_\_\_\_\_

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B. Does your child have any physical impairments or disabilities? If so, explain:

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C. Are physical characteristics or body image a concern? Explain: \_\_\_\_\_

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**V. Employment**

A. Is your child currently employed?  Yes  No

If yes,  Full time  Part time  Seasonal

B. Name of employer: \_\_\_\_\_

**VI. Spiritual Information**

A. Is spirituality an area of support or strength for your child?  Yes  No

Religion:  Catholic  Jewish  Islamic  Protestant  Other: \_\_\_\_\_

**VII. Sexual Functioning**

A. Is this an area of concern?  No  Yes, Explain: \_\_\_\_\_

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**VIII. Medical History**

A. Primary Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

B. Medications: List all current prescriptions and over-the-counter medications and supplements that you are taking.

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C. Health Issues: (Check appropriate columns)

<i>Problem</i>	<i>Never</i>	<i>Past</i>	<i>Present</i>	<i>Family History</i>
Allergies				
Anorexia				
Asthma				
Autoimmune Disorder				
Broken Bones				
Communicable Diseases				
Diabetes				
Fainting/Dizzy				
Hearing Problems				
Heart Disease				
High/Low Blood Pressure				
High/Low Blood Sugar				
Liver Disease, Jaundice				
Major Injuries				
OB/Gyn Problems				
Obesity				
Seizures/Epilepsy				
Stomach or Intestinal Problems				
Thyroid Problems				
Ulcer				
Vision Problems				

Other health problems not listed: \_\_\_\_\_

Comments: \_\_\_\_\_

Has your child ever been hospitalized for mental illness? [ ]Yes [ ] No

If yes, for what reason? \_\_\_\_\_

How long was he/she in treatment? \_\_\_\_\_ Date of hospitalization: \_\_\_/\_\_\_/\_\_\_

Hospital Name: \_\_\_\_\_ Psychiatrist: \_\_\_\_\_

**VIII. Social Life**

- A. Describe your family's strengths: \_\_\_\_\_
- B. Describe your child's support system (ie. Family, friends) \_\_\_\_\_
- C. Describe your child's recreational interests: \_\_\_\_\_
- D. Describe any relationship problems with friends/peers: \_\_\_\_\_

**IX. Health History**

- A. Primary Physician: \_\_\_\_\_
  - i. Address: \_\_\_\_\_
  - ii. Phone: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_
- B. Medications: List all current prescriptions, regularly taken over the counter meds:  
\_\_\_\_\_  
\_\_\_\_\_
- C. Concerns about medications? \_\_\_\_\_

**X. Developmental Issues**

- A. List any developmental skills that your child accomplished ahead of or behind others the same age, (ie, walking, talking, reading, etc.): \_\_\_\_\_  
\_\_\_\_\_

**XI. Nutrition**

Generally good?  Yes  No Special diet? \_\_\_\_\_

**XII. Mental Status Information**

Are you currently thinking about suicide or harming yourself in any way?  Yes  No  
Have you ever had thoughts about suicide or harming yourself in anyway?  Yes  No  
Are you having any thoughts about harming anyone else in any way?  Yes  No

**XII. Abuse History**

Have you experienced physical, sexual or emotional abuse:  Yes  No  
If yes, please explain: \_\_\_\_\_

**XIII. Legal History**

- A. Does your child have any history of legal charges?  No  Yes, Explain: \_\_\_\_\_  
\_\_\_\_\_
- B. Is your child currently on probation?  Yes  No  
If yes, probation officer's name: \_\_\_\_\_
- D. Is treatment court ordered? \_\_\_\_\_

