Wellness Associates, LLC

1271 Ethereal Circle | Colorado Springs, CO 80904
719.323.8909 | Info@WellnessAssociatesllc.org

Child & Adolescent Intake Form

Child's Full Name: _____ Date of Birth: _____ Age: _____
Person(s) completing this form: _____ Today's date: _____
Living Arrangement: ❑ Two Parents ❑ One Parent ❑ Multiple Homes ❑ Guardian/Foster Home ❑ Other
Pertinent health information (i.e. hospitalizations, medications): _____

Mother / Guardian: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Preferred Phone: _____Voicemail (yes/no) Alternate Phone: _____ Voicemail (yes/no)
Texting - appointment schedule/reminder only (yes/no) Email: _____
Relationship: ❑ Biological Mother ❑ Adoptive Mother ❑ Other (please specify) _____
Status: ❑ Married ❑ Divorced ❑ Remarried ❑ Never Married ❑ Other (please specify) _____

Father / Guardian: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Preferred Phone: _____Voicemail (yes/no) Alternate Phone: _____ Voicemail (yes/no)
Texting - appointment schedule/reminder only (yes/no) Email: _____
Relationship: ❑ Biological Mother ❑ Adoptive Mother ❑ Other (please specify) _____
Status: ❑ Married ❑ Divorced ❑ Remarried ❑ Never Married ❑ Other (please specify) _____

Divorced: ❑ Joint custody ❑ Sole custody–Mother ❑ Sole custody–Father ❑ Custody resolved
❑ Custody Evaluation in Progress ❑ Custody Being Contested ❑ Other (please specify)_____
Stepparents Name(s): _____
Preferred Phone: _____Voicemail (yes/no) Alternate Phone: _____ Voicemail (yes/no)
Texting - appointment schedule/reminder only (yes/no) Email: _____
Emergency Contact: _____
Preferred Phone: _____Voicemail (yes/no) Alternate Phone: _____ Voicemail (yes/no)

Current Concerns (Please circle all that apply):
Nervousness, Depression/Sadness, Angry/Aggressive, School Problems, Eating Difficulties, Self-Control, Shyness, Drug/Alcohol Use, Head/Stomach Aches, Loneliness, Feeling Inferior, Difficult to Discipline, Fears, Legal Problems, Sleep Difficulties, Fatigue, Difficulty with Friends, Attention/Memory, Nightmares, Separation, Loss of Interest, Suicidal Thoughts, Difficulty Relaxing, Troubling Thoughts, Other : _____
What would you like to achieve through counseling for this child? _____
_____
How do you hope counseling might change things for you/your family? _____
_____
Do you have any concerns regarding counseling? _____

Parent / Guardian Signature: _____ Date: _____
Parent / Guardian Signature: _____ Date: _____

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Child & Adolescent Intake Form

Current School grade: _____ Grade: _____
Academic or Behavioral Concerns: _____
Special Education: _____ Diagnosed Disability: _____
Organized Sports / Extracurricular Activities: _____
Which subjects/activities in school does this child enjoy the most? _____
Which subjects/activities in school are most difficult? _____
Description of child's social interactions at school: _____

Family History

Previous Counseling: _____
Current Counseling: _____
Inpatient Mental Health Treatment: _____
Suicide/Attempted Suicide: _____
Depression/Anxiety: _____
Learning Disabilities: _____
Physical, Emotional, Sexual Abuse or Neglect: _____
Drug and/or Alcohol Abuse: _____
Serious Illnesses/Injuries: _____
Legal Difficulties: _____
Other: _____
Major changes your child and/or your family have experienced during the past 5 years: _____
_____

Siblings

	Name	Date of Birth	Description of Relationship (How do they get along?)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Other Family or Important People in Child's Life

	Name	Age	Description of Relationship (How do they get along?)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Developmental History

Problems during pregnancy? (yes/no) Please describe: _____
Did mother smoke, drink, use drugs, experience illness or accident during pregnancy? (yes/no)
Please explain: _____