ICA INTAKE FORM

Date: ___________

Child to Receive Treatment-General Information

Name:	Date of Birth:	Gender: ☐ Female ☐ Male
School Attending:	Grade	
Cell Phone:	Email Address:	
How much contact per month does the child have with his/her biological mother/father: ☐N/A		
Extracurricular activities/interests:		

Legal Guardian Information

Parent/Guardian Name:		
Relationship to Child: ☐ Biological Parent(s) ☐ Adoptive Parent(s) ☐ Other:		
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Cell Phone:	Email Address:	
May we call you and leave a message at home? *Yes No* May we call you and leave a message at work? *Yes No* May we send mail to you at this address? *Yes No*		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Spouse/Partner:		

Current Caregiver (who the child resides with)

☐ Same as Legal Guardian (fill in only information that is different from that listed above)		
Name:		
Relationship to Child: ☐ Foster Parent(s) ☐ Biological Relative-Specify: ☐ Group Home ☐ Other:		
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Cell Phone:	Email Address:	
May we call you & leave a message at home? *Yes No* May we call you & leave a message at work? *Yes No* May we send mail to you at this address? *Yes No*		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Spouse/Partner:		

Household Information

Children in the Home			
Name	**Date of Birth**	**Gender**	**Relationship to Client**
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
Caregiver Occupations:			
Caregiver Highest Level of Education: ☐ Some High School ☐ High School Diploma ☐ Some College ☐ College Degree ☐ Some Graduate Work ☐ Master's Degree ☐ Doctoral Degree			

Emergency Contact Information

Name:		Relationship to Child:
Home Phone:		Work Phone:
Cell Phone:		Email Address:
Address:		
City:	State:	Zip:

Requested Services

Please check the corresponding box for the service(s) that you are requesting or for which you have been referred. (Upon the initial intake assessment, the counselor will evaluate and determine the best course of treatment based on the clinical need for each client, including but not limited to services being held in-office and/or in-home, etc.)

☐ Individual Therapy	☐ Family Therapy
☐ Group Counseling	☐ Respite Care
☐ Coaching	☐ Behavioral Management Therapy
☐ Therapeutic Assessments/Evaluations	☐ IEP/504 Advocating
☐ Parenting Skills Training	☐ Social Skills Training
☐ Other (please describe):	

Reason for Seeking Help

What concerns about the child have brought you to counseling:
Where are these concerns causing the most problems for YOU? (check all that apply) ☐ Home ☐ Work ☐ Marriage/Relationship ☐ Other:

Where are these concerns causing the most problems for the CHILD? (check all that apply) ☐ Home ☐ Work ☐ Marriage/Relationship ☐ Other:
When did the present concerns begin to be a problem for the child?
What concerns about the child have been identified by others?

Please indicate which of the following are currently problems the child experiences. Check all that apply:

☐ Crying Spells	☐ Hyperactivity
☐ Excessive Fears or Anxieties	☐ Bullying/ Picking Fights
☐ Difficulty Being Away from Specific Family Members	☐ Difficulty with Authority
☐ Hearing Voices	☐ Nightmares
☐ Getting into Trouble at School	☐ Temper Tantrums
☐ Obsession/Compulsion with Specific Activities	☐ Lack of Motivation
☐ Difficulty Falling Asleep	☐ Unable to Sleep at Night
☐ Lack of Self Confidence	☐ Difficulty Making/Keeping Friends
☐ Decreased/Increased Appetite	☐ Loss of Interest in Usual Activities
☐ Other: ______________________________	

Treatment & Psychiatric History

Has the child received previous treatment? ☐ Yes (complete the information below) ☐ No When: For how long: For what concern:
Has the child ever been diagnosed with or treated for any type of mental illness? ☐ Yes ☐ No If yes, which type?
Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness? ☐ Yes ☐ No If yes, which type?

Please list any psychiatric medications your child is currently taking:	
Psychiatric Medication(s)	**Dosage**

Medical History

How would you rate your child's current physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor			
Is the child currently complaining of any physical problems (e.g. headaches, stomach aches)? ☐ Yes ☐ No If yes, which type?			
Primary Care Physician			
Name:	Associated Hospital:		
Address:	City:	State:	Zip:
Phone:	Notes:		
Previous Hospitalization for Medical Reasons:			
Date:	Reason:		
Date:	Reason:		
Please list any medical conditions/disabilities:			
Please list any learning disabilities:			

Please list any medications your child is currently taking:	
Medication(s)-Over the counter & Prescription	**Dosage**

Your signature below indicates that at the Initial Intake appointment you have been advised of and agree to: Limits of Confidentiality, Risk and Benefits of Treatment, Attendance Policy, Fee Policies, After-hours emergency contact, Informed Consents (2), Receipt of Privacy Practices, Release of Confidentiality and received a copy of the HIPAA Privacy notice.

Signature ____ Date ___________________