ICT Therapy Works
545 N Woodlawn Blvd. Wichita, KS 67208
316-260-6889

Child / Adolescent Intake Form

Date: _____

Child's Name: _____
First Middle Last

Age: _____ DOB: _____ Insurance: _____

School Information

School: _____ School Phone #: _____

School Address: _____

Teacher's Name: _____ Grade: _____

Parent Information

Parent's Name: _____ DOB: _____
First Middle Last

Address: _____

Home Phone #: _____ Work Phone #: _____

Place Of Employment: _____

Does this parent carry insurance on this child? ▫ Yes ▫ No

Insurance Type: _____

Parent's Name: _____ DOB: _____
First Middle Last

Address: _____

Home Phone #: _____ Work Phone #: _____

Place Of Employment: _____

Does this parent carry insurance on this child? ▫ Yes ▫ No

Insurance Type: _____

Sibling Information

	First Name	Last Name	Age	DOB
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____
6	_____	_____	_____	_____

Legal History

Has the child ever been arrested? ▫ Yes ▫ No

If yes, indicate what for and when: _____

Medical History

Does the child have any significant health issues? ▫ Yes ▫ No

If yes, what is / are the health issues? _____

Is the child limited in any way? _____

Date of the child's last medical exam: _____

Doctor's name: _____

Doctor's phone #: _____

Psychiatric History

Has the child ever been in therapy? ▫ Yes ▫ No

If yes, please specify:

Dates	With Whom	Presenting Issues	Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication History

Has the child currently taking any medications? ▫ Yes ▫ No

If yes, please specify:

Medication	Condition	Dosage	Date Of Use	Side Effects	Physician

Alcohol / Drug Use

Is the child currently using drugs or alcohol? ▫ Yes ▫ No

If yes, please specify:

Type	Dosage	Dates Of Usage	Frequency

When did the child start using drugs or alcohol? _____

What has the child's past use of alcohol been like? _____

Suicide Risk

Has the child ever thought about or tried to hurt themself? ▫ Yes ▫ No

If yes, when? _____

How many times? _____

How or what did the child do? _____

What were the circumstances at the time? _____

Has anyone close to the child committed suicide? ▫ Yes ▫ No

If yes, who, how and when? _____

Abuse History

Has the child ever physically, emotionally or sexually abused? ▫ Yes ▫ No

If yes, briefly explain who, what and when: _____

_____

Symptom Checklist

Check the following symptoms that the child has experienced in the last thirty (30) days:

▫ Sleep disturbance	▫ Weight change	▫ Tension
▫ Withdrawal	▫ Change in eating behavior	▫ Lack of motivation
▫ Physical complaints	▫ Easily annoyed or irritated	▫ Restlessness
▫ Uncontrolled temper outbursts	▫ Guilt, remorse, shame	▫ Negative/intrusive thoughts
▫ Decreased sex drive	▫ Uncontrolled/unprovoked crying	▫ Lack of concentration
▫ Feeling down or depressed	▫ Generalized anxiety	▫ Difficulty with decisions
▫ Specific anxiety or phobia	▫ Panic attacks	▫ Feeling of being watched
▫ Nervousness	▫ Fear	▫ Excessive worry

Support Systems

Does the child have people they can turn to for support? ▫ Yes ▫ No

If yes, who? _____

What do you feel are the child's strengths? _____

_____

Briefly explain why the child is seeking counseling at this time: _____

_____

What does the child hope to achieve through counseling? _____

_____