



CARE AND COUNSELING CENTER of Georgia

OFFERING HEALING, HOPE AND EDUCATION IN THE PASTORAL TRADITION

WWW.CCCGEORGIA.ORG

Office Use Only

Client # _____

Ins. Dx: _____

Need Monthly Statement?

Yes No

Therapist: _____

Therapist # _____

Center # _____

EAP Yes No

CHILD/ADOLESCENT CLIENT INTAKE INFORMATION FORM

Today's Date: _____

GENERAL INFORMATION – Please print

Name: Last _____ First: _____ MI: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Responsible Party

Name: Last _____ First: _____ MI: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Preferred leave msg?

Home Phone _____ Y N Email Address: _____

Cell Phone _____ Y N

DOB: ____/____/____ Age: _____ Male Female SSN: _____-_____-_____

School Attending: _____ Grade: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Racial/ethnic identity: American Indian or Alaska Native Asian or Asian Indian Black or African-American
 Hispanic or Latino Middle Eastern Pacific Islander or Native Hawaiian White

Religious/Denominational Preference: _____

Referred by: _____ May we thank the person? Yes No

FAMILY INFORMATION

Parents' Marital Status: Single Engaged Married/Partnered Separated Divorced Widowed

Mother's Name: _____ DOB: ____/____/____ Age: _____ SSN: _____-_____-_____

Preferred leave msg?

Home Phone _____ Y N Email Address: _____

Work Phone _____ Y N

Cell Phone _____ Y N Employer: _____

Father's Name: _____ DOB: ____/____/____ Age: _____ SSN: _____-_____-_____

Preferred leave msg?

Home Phone _____ Y N Email Address: _____

Work Phone _____ Y N

Cell Phone _____ Y N Employer: _____

Others living in child's home (Names, relationship to child, age) _____

Legal Custodian (if applicable): _____

INSURANCE INFORMATION (if applicable)

Policyholder's Name: _____ Policyholder's Employer: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Policyholder's SSN: ____-____-____ Policyholder's DOB: ____/____/____ Relationship to Client: _____

Primary Insurance Carrier: _____ Street Address: _____

City: _____ State: _____ Zip: _____ Policy #: _____ Group #: _____

Preauthorization Required? Y N Phone: _____

Secondary Insurance Carrier: _____ Street Address: _____

City: _____ State: _____ Zip: _____ Policy #: _____ Group #: _____

Preauthorization Required? Y N Phone: _____

Would you like to join our email list for upcoming workshops and groups? Yes No

(We respect your email privacy. You will not receive unsolicited marketing. We will not share, transfer, sell or rent your information.)

COUNSELING CONCERNS

Why are you seeking help for your child now?

What would you like to see happen as a result of counseling or psychotherapy?

MEDICAL & PSYCHOLOGICAL HISTORY

Physician's Name: _____ Physician's Phone: _____

Date of last physical: _____

List physical illnesses or symptoms Check if none

Current Medication	Dosage	Frequency	Prescribing MD
_____	_____	_____	_____
_____	_____	_____	_____

Psychiatrist's Name: _____ Psychiatrist's Phone: _____

Has your child ever had counseling or psychotherapy in the past? Yes No

If yes, when? _____ With whom? _____

Have you or any other family member received help for drug or alcohol dependency? Yes No

If yes, when? _____ Where? _____

Check which of the following your child uses, and note the amount and frequency of each:

- Caffeine: _____ Tobacco: _____
 Coffee Sodas Other drinks Pills
- Alcohol: _____ Marijuana: _____
 Cocaine, Crack: _____ LSD: _____
 Inhalents: _____ Other: _____

Have you ever been concerned about your child's use of drugs/alcohol? Yes No

Has your child been concerned or felt guilty about his/her use of drugs/alcohol? Yes No

Has anyone ever expressed concern about your child's use of drugs/alcohol? Yes No If yes, who? _____

Are drugs used in the home? Yes No If so, what and by whom? _____

Is alcohol used in the home? Yes No If so, what and by whom? _____

Does anyone in the home smoke? Yes No If so, who does and how much? _____

Interests and Accomplishments

What are your child's main hobbies and interests? _____

What are your child's areas of greatest accomplishment? _____

What does your child enjoy doing most? _____

What does your child dislike doing most? _____

What do you like about your child? _____

How much time does your child spend:

Doing homework? _____ Watching TV? _____

Playing video games? _____ On the computer? _____

Exercising? _____ Sleeping? _____

Checklist of Concerns for Children

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Careless | <input type="checkbox"/> Fidgets | <input type="checkbox"/> Loses temper | <input type="checkbox"/> Bullies |
| <input type="checkbox"/> Poor sustained attention | <input type="checkbox"/> Out-of-seat | <input type="checkbox"/> Argumentative with adults | <input type="checkbox"/> Destroys property |
| <input type="checkbox"/> Doesn't listen | <input type="checkbox"/> Runs about | <input type="checkbox"/> Angry or resentful | <input type="checkbox"/> Physical fights |
| <input type="checkbox"/> Poor follow-through | <input type="checkbox"/> Problems being quiet | <input type="checkbox"/> Refuses to comply | <input type="checkbox"/> Cruel to animals/people |
| <input type="checkbox"/> Poor organization | <input type="checkbox"/> Talks excessively | <input type="checkbox"/> Deliberately annoys | <input type="checkbox"/> Uses a weapon |
| <input type="checkbox"/> Loses things | <input type="checkbox"/> Calls out | <input type="checkbox"/> Projects blame | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Doesn't wait turn | <input type="checkbox"/> Easily annoyed | <input type="checkbox"/> Truant from school |
| <input type="checkbox"/> Forgetful in daily activities | <input type="checkbox"/> Interrupts | <input type="checkbox"/> Spiteful or vindictive | <input type="checkbox"/> Sets fires |

I give permission to CCCG to treat the minor I am bringing for counseling.

Signature of parent/guardian

Date

Printed name of parent/guardian

Checklist of Concerns

Please check any relevant concerns.

THOUGHTS/FEELINGS/MOOD

- Anger/frustration/hostility
- Anxiety, nervousness
- Attention, concentration, distractibility
- Confusion
- Depression
- Disliking others
- Emptiness
- Euphoria
- Excessive worry
- Failure
- Fatigue
- Fear
- Grieving (death, loss, divorce, etc)
- Guilt
- Hearing things other people don't
- Homicidal thoughts
- Intrusive thoughts
- Judgment problems
- Memory difficulties
- Negative thoughts
- Obsessive thoughts
- Oversensitivity to criticism
- Oversensitivity to rejection
- Panic attacks
- Perfectionism
- Sadness
- Seeing things other people don't
- Self-centeredness
- Self-esteem
- Shyness
- Spiritual, religious, or moral issues
- Stress
- Sudden mood changes
- Suicidal thoughts
- Suspiciousness
- Temper problems
- Thoughts of hurting self or others

BEHAVIOR

- Aggression, violence
- Alcohol use
- Argumentative
- Avoidant
- Compulsive behavior/rituals
- Controlling
- Decreased/lack of sexual interest
- Dependency
- Destruction of property
- Drug use – prescription, over-the-counter, street
- Eating problems
- Financial problems, debt
- Gambling
- Hyperactivity
- Internet problems
- Irresponsibility
- Isolation
- Legal problems
- Letting others take advantage of you
- Lying
- Not able to relax
- Pornography
- Preoccupation with sex
- Procrastination
- Purging
- Self destruction/sabotaging
- Self-neglect
- Sexual dysfunction
- Smoking
- Stealing
- Threats
- Weight gain or loss
- Withdrawal from others
- Loss of interest on what I used to like
- Sleep difficulty
- Loss of appetite
- Overeating

FAMILY & RELATIONSHIPS

- Affair
- Childhood issues (your childhood)
- Divorce
- Friendships
- Housework/chores
- Interpersonal conflicts
- Parenting
- Problems with child(ren)
- Problems with parents
- Problems with spouse/partner
- Separation

ABUSE

- Abuse of alcohol
- Abuse of drugs
- Emotional abuse by another
- Emotional abuse of another
- Financial abuse
- Neglect
- Physical abuse by another
- Physical abuse of another
- Sexual abuse by another
- Sexual abuse of another
- Verbal abuse

WORK & SCHOOL

- Absenteeism
- Career concerns, goals, choices
- Difficulty with coworkers
- Difficulty with supervisor
- Performance
- Tardiness
- Procrastination
- School problems

OTHER CONCERNS

- _____
- _____
- I have no problems or concerns bringing me here at this time.