Ventura Community Counseling

build a healthy relationship with the heart and mind

Adolescent/Child Intake Form

Child's Name:_____ Age:_____DOB: _____

Sibling: _____ Age:_____DOB: _____

Sibling: _____ Age:_____DOB: _____

Sibling: _____ Age:_____ DOB: _____

Sibling: _____ Age:_____ DOB: _____

***1. Parent's Name*:** _____ DOB: _____

Address (City, State and Zip):_____

Marital Status:_____ Male/Female: _____

Phone: H(____)_____W(____)_____C(____)_____

OK to say VCC? Yes _____ No_____

Emergency contact (name and phone #)_____

***2. . Parent's Name*:** _____ DOB: _____

Address (City, State and Zip):_____

Marital Status:_____ Male/Female: _____

Phone: H(____)_____W(____)_____C(____)_____

OK to say VCC? Yes _____ No_____Emergency contact (**name and phone #**)_____

3. *Step Parent(s)/Guardian(s)*:_____ DOB: _____

Address: _____

City, State and Zip: _____Marital Status:_____ Male/Female:____

Phone: H(___)_____ W(___)_____ C ( )_____

OK to say VCC? Yes _____ No_____Emergency contact (**name and phone #**)_____

Please describe current concerns or problems:_____

_____

_____

_____

How long has the problem existed? _____

_____

Have there been any significant stressors for your family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

_____

_____

_____

What attempts have been made to resolve the difficulties?_____

_____

Please check the symptoms that you / child / adolescent is currently experiencing. Please indicate when the symptom began, duration, and severity using the scale provided.

Severity of Symptom:
None Mild Moderate Severe
0 1 2 3

Symptom	*When symptom began?*	*How long?*	
Sadness or Depression			
Suicidal Thoughts			
Sleep Problems			
Changes in Appetite			
Weight Change			
Inability to Concentrate			
Obsessive thoughts			
Tension and Anxiety			
Panic Attacks			

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Symptom	*When symptom began?*	*How Long?*	*Severity of symptom* *None Mild Moderate Severe* *0 1 2 3*
Memory Problems			
Compulsive Behaviors			
Feelings of Hostility			
Acts of Violence			
Social Isolation			
Strange Thoughts			
Stomach Aches			
Head Aches			
Bed Wetting			
Phobias			
Other			

Remainder to be completed by Parent(s) or Guardian:

Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, etc)?

_____

_____

_____

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For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)_____

_____

_____

Is ex-spouse (biological parent) aware that you are bringing their children to VCC? Yes_____ No_____

If not, please explain._____

_____

_____

If adopted, does child know of adoption? Yes _____ No _____

What age was your child at the time of the adoption?_____

Mother's Name: _____ Age: _____ Occupation: _____

Employment status: _____ Employer's name and address: _____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Current and past psychiatric treatment or counseling:_____

Currently prescribed medications:_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use?_____

History of arrest?_____

Primary Care Physician:_____

Psychiatrist:_____

Father's Name:_____ Age: _____ Occupation: _____

Employment status: _____ Employer's name and address: _____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Current and past psychiatric treatment or counseling:_____

Currently prescribed medications:_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use?_____

History of arrest?_____

Primary Care Physician:_____

Psychiatrist:_____

Step-parent/Guardian:_____ Age: _____ Occupation: _____

Employment status: _____ Employer's name and address: _____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Current and past psychiatric treatment or counseling:_____

Currently prescribed medications:_____

Current alcohol/drug use (amount, how often, intoxication frequency):_____

_____

History of alcohol/drug use?_____

History of arrest?_____

Primary Care Physician:_____

Psychiatrist:_____

Child Information:

1). Name of Child:_____ Age:_____ Child lives with:_____

School:_____ Grade:_____ Teacher: _____

History of psychiatric treatment or counseling:_____

Current or past drug or alcohol use (indicate past or present amount, frequency)_____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Medications currently prescribed:_____

Pediatrician:_____

Psychiatrist:_____

2). Name of Child:_____ Age:_____ Child lives with:_____

School:_____ Grade:_____ Teacher: _____

History of psychiatric treatment or counseling:_____

Current or past drug or alcohol use (indicate past or present amount, frequency)_____

_____

Significant medical problems:_____

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Serious illnesses, accidents, or surgeries in the past:_____

Medications currently prescribed:_____

Pediatrician:_____

Psychiatrist:_____

3). Name of Child:_____ Age:_____ Child lives with:_____

School:_____ Grade:_____ Teacher: _____

History of psychiatric treatment or counseling:_____

Current or past drug or alcohol use (indicate past or present amount, frequency)_____

_____

Significant medical problems:_____

Serious illnesses, accidents, or surgeries in the past:_____

Medications currently prescribed:_____

Pediatrician:_____

Psychiatrist:_____

How did you hear about VCC?_____

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