Awakenings Christian Counseling 4250 S. Westnedge Kalamazoo MI 49008
Email: counsel@awakeningscc.com Phone: 269-234-2343

CHILD / ADOLESCENT
INTAKE ASSESSMENT Date_____

Child's name_____ M F
Address_____ DOB_____
City_____ State_____ Zip Code_____ Phone# _____
Parent(s)/Guardian(s)_____
Email Address _____Alternate Phone #_____
Emergency contact_____ Relationship_____ Phone_____
Who lives in the home at the current time? (Name, age, relationship) _____
_____
_____
_____
Reason for seeking counseling: _____
_____
_____
_____

Has the child had previous counseling: _____ Yes _____ No _____ Only as part of family
Where _____ When_____
Was it helpful? _____
_____
_____

Has the child had previous substance abuse treatment? _____ Yes _____No _____Only as part of family
Where _____ When_____
Was it helpful? _____
_____
_____

EDUCATIONAL HISTORY

School_____ Grade_____ Teacher_____
School Counselor / Social Worker_____
Has the child ever been diagnosed? _____ Learning Disability _____ ADHD _____ Sensory Integrative
_____Autism _____ Oppositional Defiant _____ Emotionally Impaired
_____ Pervasive Development Dis. _____ Physical Impairment
Describe the child's academic performance_____
_____
Does the child struggle with distractibility? _____ Yes _____ No _____ School thinks so, I'm not sure
_____ Sometimes

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Has the child struggled with any of the following? _____ Truancy _____ Suspension _____Fighting _____ Vandalism _____Expulsion _____Defiance _____School refusal _____Threatening behaviors _____ Weapons _____ Separated from parent

What does the child do well at school? _____
Has the child ever been held back? _____ No _____ Yes, when? _____

LEGAL SYSTEM INVOLVEMENT

Has the child been involved with the legal system? _____ Yes, in the past _____ Currently _____ No
If so, please explain _____
_____
Is the child on probation? _____ No _____ Yes, probation officer _____

FAMILY HISTORY

Does anyone in the extended family unit have a history of alcoholism? ____ No _____ Yes, please explain _____
_____
Drug abuse? _____No _____Yes, please explain_____
Depression? _____No _____ Yes, please explain_____
Anxiety? _____ No _____Yes, please explain _____
Mental Illness? _____No _____Yes, please explain_____
Has the child ever been abused? _____No _____Yes, _____Physical _____Emotional _____Sexual _____ Spiritual _____ Verbal
Explain _____

HEALTH HISTORY

Where was the child born? _____ Adopted? _____ No _____Yes, at age_____
Explain any complications the mother had during pregnancy or labor _____
_____
Child's physician / pediatrician _____
Is the child being treated for a medical condition? _____
_____
_____
Please list hospitalizations _____
_____
Please list current medications _____

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_____
_____
_____
Please list current allergies _____
_____
Has the child ever had a seizure? ____ No ____Yes, specify _____
Has the child ever had a head injury? ____ No ____Yes, specify _____
Does the child complain of frequent headaches? ____ No ____Yes, specify _____
Does the child complain of dizziness? ____No ____Yes, specify _____
Does the child have current difficulties with wetting/soiling? ____No ____Yes, specify _____
_____
Does the child have adequate personal hygiene habits? ____ No ____Yes

At what age did the child walk _____ Talk _____ Complete toilet training _____
Eating habits? ___ No change ___ Not eating ___ Over-eating ___ Significant Weight Change ____ lbs.
____ Selective Eating Habits _____ ____ Other _____
Sleeping Habits? ____No Change ____ Trouble Getting to Sleep ____ Trouble Staying Asleep
____ Early Waking ____ Sleepwalking ____ Nightmares/terrors ____ Other _____

HARMFUL BEHAVIORS

Are you concerned about suicidal statements or gestures with the child? ____ No ____ Yes, explain
_____
Prior attempt? Explain _____

Are you concerned about the child seriously injuring others? ___ No ____Yes, explain _____
_____
Prior attempt? Explain _____

Others risk/safety factors_____
_____

PERSONALITY

Does the child form friendships easily? ____Yes ____ No ____ Only in small crowds
Does the child struggle with any of the following? ____ "Late Bloomer" ____ Bullying ____ Easy Target ____ Extremely Shy ____ Needs Social Reassurance ____ Other _____
Who is the child's best friend at the current time? _____
What does the child do well socially? _____
_____
_____
What are some of the child's favorite activities / toys? _____

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_____
_____
_____

Is the child part of any groups/organizations ___No ____Yes
If yes, what? _____
Cultural Heritage _____

SPIRITUALITY

Is your family affiliated with a church? ____ No ____Yes, where? _____
Who is the minister/reverend? _____
How often do you attend? ___ Regularly ____ Sporadically ____ Holidays ____ Never
Is the child involved in a church youth group? ____ No ____ Yes ____ Sometimes

PREPARATION FOR COUNSELING

Have you spoken with the child about why he / she is coming to counseling? ___ No ____ Yes
What is the last major change in the child's life? _____
_____
Has the child ever experienced a traumatic event? ____ No ____ Yes, explain _____
_____

Is there anything else that the therapist should know about the child? _____
_____
_____
_____
Is there anyone else who should be invited into the counseling process with the child? ____ No
____ Yes, whom? _____
Comments _____
_____
_____

TREATMENT PLANNING

What would you like to see occur from counseling services for the child? _____
_____
_____
_____
How frequently would you like the child's counseling sessions to be scheduled?
___ as needed ___ 1x/month ____ 2x/month ____ 3x/month ____ 4x/month ____ don't know yet

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Is everyone in the child's family aware of the concerns? _____ Yes _____ No
Is everyone in the family willing to participate in counseling? _____ Yes _____ No _____ Don't know

Is there anything else the child's counselor should know? _____
_____
_____
_____
_____
_____

Therapist Review: Date: