Aspiring Hearts Counseling, PLLC
Mending Hearts... Changing Lives.

Child / Adolescent Intake Questionnaire

Client Name:			Date:	
Parent/Guardian Name:				
Birth Date:	Age:	Soc Sec Num:		
Address:				
Home Phone:		Ok to leave messages?	☐ Yes	☐ No
Cell Phone:		Ok to leave messages?	☐ Yes	☐ No
Work Phone:		Ok to leave messages?	☐ Yes	☐ No
Email:				

Reasons for Services/Symptoms (Check all that apply)

☐ Depression / Sadness	☐ Anger	☐ Anxiety / Worry	☐ Career Counseling	☐ Poor Memory
☐ Poor Focus	☐ Impulsive	☐ Panic Attacks	☐ Difficulty w/ Instructions	☐ Poor Behaviors
☐ Suicidal Thoughts	☐ Tantrums	☐ Mood Swings	☐ Crying Spells	☐ Difficulty Coping
☐ Withdrawal/Isolation	☐ Excessive Guilt	☐ Poor Grades	☐ Poor Concentration	☐ Fears / Phobias
☐ Obsess/Compulsions	☐ Addictive Behaviors	☐ Sexual Issues	☐ Change in Appetite	☐ Bowl Movement Change
☐ Nightmares	☐ Sleeping Problems	☐ Mania	☐ Excessive Talking	☐ Low Energy
☐ Hyperactive	☐ Talking Back	☐ Paranoia	☐ Overwhelmed	☐ Unreasonable Avoidance
☐ Defiance	☐ Confusion	☐ Aggressive	☐ Self-Injurious Behaviors	☐ Social Problems
☐ Easily Distracted	☐ Grief / Loss / Death	☐ Messy	☐ Difficulty Finishing Tasks	☐ Homework Problems
☐ Poor Decisions	☐ Excessive Lying	☐ Fighting	☐ Difficulty Sitting Still	☐ Stealing
☐ Impulsive	☐ Manipulative	☐ Fire Setting	☐ Cruelty To Animals	☐ Poor Hygiene
☐ Bed Wetting	☐ Hallucinations	☐ Interrupting	☐ Overly Dependent	☐ Doesn't Share Feelings
☐ Unusual Thoughts	☐ Toileting Problems	☐ Has Accidents	☐ Repetitive Behaviors	☐ Strange/Rigid Behaviors
☐ Suicidal Thoughts	☐ Homicidal Thoughts	☐ Is Bullied	☐ Body Image Problems	☐ Parent Divorce/Separation
☐ Low Self-Esteem	☐ Bullies Others	☐ Runs Away	☐ Excessively Shy	☐ Significant Life Change
☐ Destroys Property	☐ Skips School	☐ Disrespectful	☐ Dangerous Behavior	☐ Few Friends
☐ Others:				

When did the problems/symptoms start?

16 W. Martin St., Suite 401 ♥ Raleigh, NC 27601 ♥ 919-538-3458 ♥ Fax: 1-888-325-6160 ♥ info@aspiringhearts.com
www.aspiringhearts.com

What goals do you want therapy to assist your child with?

☐ Learn to cope with feelings/anger ☐ Follow rules/directions better ☐ Perform better in school

☐ Make better choices ☐ Improve self-esteem/confidence ☐ Improve relationships

☐ Others:

Has client ever been arrested or been involved in a significant legal situation? ☐ Yes ☐ No (If No continue to next section)		
Number of Arrests	Any pending charges? ☐ Yes ☐ No	Currently on probation or parole? ☐ Yes ☐ No

Has client experienced anything traumatic? (check all that apply) ☐ No Trauma

☐ Physical Abuse ☐ Sexual Abuse ☐ Rape ☐ Domestic Violence ☐ Traumatic Injury

☐ Traumatic Accident ☐ Assault ☐ Robbery ☐ Death or Loss ☐ Witnessed Trauma

☐ Other

Does client use any substances? ☐ None ☐ Tobacco ☐ Smokeless Tobacco ☐ Alcohol ☐ Drugs

Has client received mental health treatment in the past? ☐ Yes ☐ No	Has client been a patient of a mental hospital within the past year? ☐ Yes ☐ No
If Yes, what agencies?	

If Yes, what services have been tried? (check all that apply) ☐ Outpatient Therapy ☐ Inpatient Treatment ☐ Intensive In-Home

☐ Case Management ☐ Medication Management ☐ Group Home ☐ PRTF ☐ Hospitalization ☐ Other

Does client have a psychiatrist? ☐ Yes ☐ No Name/Agency:

Physician Name/Agency:	Phone:
Date of last physical:	Allergies:
Medical Problems:	

Do you take any prescription or regular over the counter medications? ☐ Yes ☐ No (If yes, list below)

Medication	Dosage	Frequency	Reason for Medication

Medication concerns / Notable side effects

Client's Employment Status: ☐ None ☐ Odd Jobs for Money ☐ Part-Time Job ☐ Volunteers ☐ Wants to Find a Job

Client's Relationship Status: ☐ None ☐ Has a boyfriend/girlfriend ☐ Dates ☐ Sexually Active

Client's Current School: | Current Grade:

School Schedule: ☐ Traditional ☐ Modified ☐ Year Round [If Year Round, which track]:

School Performance: ☐ Above Average ☐ Average ☐ Below Average ☐ Failing

Educational Concerns: (check all that apply)

☐ No Educational Concerns

☐ Regular Disciplinary Actions ☐ Has an IEP ☐ Attendance Problems ☐ Problems with Peers

☐ Needs an IEP or 504 ☐ Has a 504 ☐ Learning Disabilities ☐ Bullied by Others

☐ Fails to Complete or Turn in Homework ☐ Suspensions ☐ Fighting/Bullying ☐ In the Process of Obtaining IEP or 504

☐ Other:

How would you describe the current family situation and info about client's childhood: (Check all that apply)

☐ No Family Problems ☐ Typical Minor Family Problems ☐ Regular Family Fighting

☐ Blended Family ☐ CPS Involvement ☐ Estranged from Some Family Members

☐ Single Parent Family ☐ Mother Remarried ☐ Father Remarried

☐ Client's Parents Divorced ☐ Family has Limited Time Together ☐ Client Raised by Father

☐ Client Raised by Both Parents ☐ Client Raised by Mother ☐ Client was Adopted

☐ Client Custody is Split between Parents ☐ Raised by Another Family Member ☐ Close Family

☐ Client has been in Foster Care ☐ Client has been Abused in Family ☐ Upper Class Family

☐ Low Socioeconomic Class Family ☐ Middle Class Family ☐ Other

What is Client's Mother's Name:

How would you describe client's relationship with his/her mother?

☐ Very Close ☐ Great ☐ Good ☐ Up and Down ☐ Tense ☐ Poor ☐ Abusive ☐ No Contact ☐ Mother Deceased

What is Client's Father's Name:

How would you describe client's relationship with his/her father?

☐ Very Close ☐ Great ☐ Good ☐ Up and Down ☐ Tense ☐ Poor ☐ Abusive ☐ No Contact ☐ Father Deceased

How many Brothers does client have? | How many Sisters does client have?

How would you describe client's relationship with his/her brothers and sisters?

☐ Close with All ☐ Close with Some ☐ Good ☐ Up and Down ☐ Tense ☐ Little Contact ☐ No Contact ☐ Some Deceased

Additional Important Family Information:

Are you aware of any developmental problems when client was a baby or did his/her mother have any pregnancy or delivery complications?

☐ Pregnancy Complications ☐ Delivery Complications ☐ Speech Delay ☐ Walking Delay ☐ Motor Delay

☐ Psychological Delay ☐ Other Delay ☐ No Known Complications or Delays ☐ Unknown

Is there any Biological Family History of Mental Health Problems or Substance Abuse?

☐ No Family History of Mental Health or Substance Abuse ☐ Unknown Family History

☐ History of Mental Health Problems on Mother's Side ☐ History of Mental Health Problems on Father's Side

☐ History of Alcoholism on Mother's Side ☐ History of Alcoholism on Father's Side

☐ History of Drug Usage on Mother's Side ☐ History of Drug Usage on Father's Side

To which cultural or ethnic group, if any, does client belong?

Is there any cultural or ethnic info we should be aware of?

How religious or spiritual is the client and family? ☐ A lot ☐ Moderately ☐ A Little ☐ Not at All

Which religious/spiritual group, if any, does the client and family belong?

Describe the client's social life: (Check all that apply)

☐ Client is very social ☐ Client is moderately social ☐ Client prefers to not be social

☐ Client has a lot of friends ☐ Client has a few close friends ☐ Client has very little or no friends

☐ Client has trouble making friends ☐ Client would like to make more friends ☐ Client is not a people person

☐ Client was social but now not as much ☐ Client attends regular social situations ☐ Client would like to get out more

☐ Client avoids crowds ☐ Client avoids social situations ☐ Other

What are Client's hobbies, or things he/she likes to do:

What are the Client's strengths, or things he/she is good at:

Emergency Contact:	Relationship:
Cell Phone:	Phone:
Address:	

Initial: I give Aspiring Hearts Counseling permission to contact the above listed Emergency Contact in the event of an emergency.

_____ I understand Aspiring Hearts Counseling may have to release confidential information to the Emergency Contact.

Signature:	Date: