Center for Sexual Health
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CLIENT COMPREHENSIVE THERAPY INTAKE FORM FOR PARENTS OF CHILD/ADOLESCENT

Please fill out as completely as possible about your child/adolescent. When specified, some of the questions will also be asking information about you as parent(s).

Today's date: _____ **Parent's Name:_____**

Child/Adolescent Full Legal name: (First) (Middle) (Last) **Preferred name (if applicable):**	**DOB:** **Age:**	**Assigned Sex at Birth:** **Current Gender Identity:**

Child/Adolescent's Ethnicity (optional): ☐ Caucasian ☐ AfricanAmerican ☐ Latino/Latina/Latinx ☐ Native American ☐ Asian American ☐ Multi-racial ☐ Other (Describe): _____

How did you find out about the Center for Sexual Health?_____

1. PRESENTING PROBLEM: Please define briefly the problems, challenges, and/or concerns that your child/adolescent is experiencing for which you are seeking our services.

2. GOALS: Please list what you and your child/adolescent want to accomplish by participating in our program.

3. PERSONAL/PRIVATE INFORMATION: Are there any important things about your child/adolescent that you would like us to know (issues that might cause your child/adolescent shame, secrets, religious concerns, etc.)

4. FRIENDSHIPS: Does your child/adolescent have close friends? ☐ Yes ☐ Unsure ☐ No
Do you have any concerns about your child/adolescent's friendships?

Does your child/adolescent have romantic/sexual interactions with others? ☐ Yes ☐ Unsure ☐ No
Do you have any concerns about your child/adolescent's romantic/sexual interactions?

5. Below are a number of common **mental health concerns** for which children/adolescents need help. Please indicate whether you think any have been a concern WITHIN THE LAST SIX (6) MONTHS, by checking "yes." Check "No" only if none of the words have been an issue for your child/adolescent.

Emotional Functioning			**Physical Functioning**			**Sexual Functioning**		
☐yes	☐no	Feel flat, empty, numb	☐yes	☐no	Eating problems	☐yes	☐no	Problematic sexual behavior
☐yes	☐no	Depressed, hopeless	☐yes	☐no	Fatigue, tiredness	☐yes	☐no	Too much focus on sexual things
☐yes	☐no	Suicidal thoughts and/or behavior	☐yes	☐no	Sleeping difficulties	☐yes	☐no	STD, HIV, AIDS concerns
☐yes	☐no	Sadness and/or crying	☐yes	☐no	weight loss	☐yes	☐no	History of sexual abuse
☐yes	☐no	Irritable/moody	☐yes	☐no	overweight	☐yes	☐no	Sexual orientation concerns
☐yes	☐no	Anger and/or rage	☐yes	☐no	Alcohol abuse	☐yes	☐no	Gender concerns
☐yes	☐no	Anxiety/worry	☐yes	☐no	Drug abuse	☐yes	☐no	Not liking genitals
☐yes	☐no	Fear and/or dread	☐yes	☐no	Pain and/or nausea			
☐yes	☐no	Nervous, shaky	☐yes	☐no	Serious illness and/or health problems			
☐yes	☐no	Self-harm thoughts/behaviors						
Self-Image and Coping Issues			**Mental Functioning**			**Relationship and Life**		
☐yes	☐no	Avoidance/Denial	☐yes	☐no	Memory problems	☐yes	☐no	Conflict, fighting
☐yes	☐no	Compulsivity	☐yes	☐no	Easily distracted	☐yes	☐no	Isolation, loneliness
☐yes	☐no	Shy or sensitive	☐yes	☐no	Buzzing in ears	☐yes	☐no	Being honest about self with others
☐yes	☐no	Low self-esteem	yes	no	Voices inside head	☐yes	☐no	Death and dying concerns
☐yes	☐no	Self-hatred, guilt, shame	☐yes	☐no	Troubling thoughts	☐yes	☐no	Grieving
☐yes	☐no	Feel ugly, poor body image	☐yes	☐no	Feel paranoid	☐yes	☐no	Work or school problems
			☐yes	☐no	Troubling dreams	☐yes	☐no	Family problems

Other current concerns (Please specify) _____
_____

YOUR CHILD/ADOLECENT'S MENTAL HEALTH AND CHEMICAL DEPENDENCY HISTORY

6. ***PREVIOUS THERAPISTS (most recent first)*****:**

☐ ***NONE***

Name of therapist/clinic: _____
Address and Phone: _____
Date Therapy Began: _____ Date Therapy Ended: _____
Diagnoses Given: _____
Issues Addressed and Outcome:
_____

Name of therapist/clinic: _____
Address and Phone: _____
Date Therapy Began: _____ Date Therapy Ended: _____
Diagnoses Given: _____
Issues Addressed and Outcome:
_____

Name of therapist/clinic: _____
Address and Phone: _____
Date Therapy Began: _____ Date Therapy Ended: _____
Diagnoses Given: _____
Issues Addressed and Outcome:
_____

7. PSYCHIATRY SERVICES:

☐ ***NONE***

Name of psychiatrist/clinic: _____
Address and Phone: _____
Date Therapy Began: _____ Date Therapy Ended: _____
Diagnoses Given: _____
Issues Addressed and Outcome:
_____

8. PSYCHIATRIC HOSPITALIZATIONS ☐ *NONE*

Approx Dates & Duration:		Where:		Reason/Outcome:	
Approx Dates & Duration:		Where:		Reason/Outcome:	
Approx Dates & Duration:		Where:		Reason/Outcome:	

9. PSYCHIATRIC MEDICATIONS ☐ *NONE*

Current Prescriptions	**Dosage**	**Purpose of Medication**	**Approximate dates/Duration**	**Prescribed by *(physician/ clinic)***
Past Prescriptions	**Dosage**	**Purpose of Medication**	**Approximate dates/Duration**	

Please list any over-the-counter Medications:

_____
_____

Medication Allergies ☐Yes ☐No	Type of reaction

10. ALCOHOL/DRUG USE

Do you have any concerns about your child/adolescent in terms of alcohol or drug use? If so, please describe _____

_____

YOUR CHILD/ADOLESCENT'S MEDICAL HISTORY

11. Primary Physician/Clinic: _____

Address and Phone: _____

_____

MEDICAL PROBLEMS (DESCRIBE BELOW)	☐ NO MEDICAL PROBLEMS
Surgeries	
Medications	
Medical Problems/Illnesses	
Contraceptive Use	

YOUR CHILD/ADOLECENT'S FAMILY/SOCIAL HISTORY

12. PARENT(S)/GUARDIAN(S)

Parent/Guardian	*Age*	*Occupation*	*Health Concerns*	*Mental Health Concerns*	*Substance Abuse History & Currently*

If you are divorced, separated or never married, are both parents authorized to make healthcare decisions on behalf of your child, i.e., is there "joint legal custody" ☐ yes ☐ no

If no, which parent has sole legal custody? _____

Note: Treatment of your child at the Center for Sexual Health requires consent of both parents if there is joint legal custody.

13. SIBLINGS OF YOUR CHILD/ADOLESCENT ☐No Siblings

Name	*Age*	*Health concerns*	*Mental Health Concerns*	*Substance Abuse History & Currently*	*How would you describe their Relationship?*

Which siblings, if any, are closest to your child/adolescent?

_____

14. DESCRIBE YOUR CHILD/ADOLESCENT'S CURRENT LIVING SITUATION(S) **(if multiple households, please give brief description of each):**	
Describe any current housing problems:	

15. MAJOR CHANGES IN YOUR CHILD/ADOLESCENT'S LIFE IN THE LAST YEAR

Move/relocation	☐Yes ☐No Describe:
Blended family issues	☐Yes ☐No Describe:
Death of a family member or friend	☐Yes ☐No Describe:
Childbirth/Adoption of sibling	☐Yes ☐No Describe:
School changes	☐Yes ☐No Describe:
Child/Adolescent's Friendship/Relationships	☐Yes ☐No Describe:
Other:	☐Yes ☐No Describe:

16. ABUSE HISTORY OF CHILD/ADOLESCENT ☐ *None*

Type	Current	Past	Who abused your child/adolescent?	When/ Duration	Outcome
Sexual					
Physical					
Emotional/ Verbal					

Has your child/adolescent ever been a witness to domestic violence? ☐ Yes ☐ No	**Please describe:**
Has your child/adolescent ever been a victim of domestic violence? ☐ Yes ☐ No	**Please describe:**
Has your child/adolescent ever been physically, emotionally, verbally, or sexually abusive to others? ☐ Yes ☐ No	**Please describe:**

Has Child Protection Services ever been involved with your child/adolescent? ☐ Yes ☐ No
If yes, are they still involved? ☐ Yes ☐ No What County: _____

17. EDUCATION (Please list the schools your child/adolescent has attended)

Grade in School	*Name of School*	*Academic Concerns?*	*Behavioral Concerns?*

18. LEGAL ISSUES

Do you have any concerns about your child/adolescent in terms of legal issues? If so, please describe:

_____

_____

19. SPIRITUALITY & CULTURE

Are there any *spiritual* issues that may have an impact on your child/adolescent's treatment?	
Are there any *cultural* issues that may have an impact on your child/adolescent's treatment?	

20. LEISURE/SOCIAL ACTIVITIES

What exercise & recreational activities does your child/adolescent participate in?	
What interests or hobbies does your child/adolescent have?	

21. STRENGTHS/WEAKNESSES

What do you consider your child/adolescent's major strengths?	***What do you consider your child/adolescent's major limitations/weaknesses?***

22. Any additional comments or issues you want to add?

Thank you for taking the time to complete this form. It will be helpful in your child/adolescent's assessment and treatment.