Ashley Cygnarowicz, LPC, LLC
(Child & Adolescent Intake)

Name: _____
(LAST) (FIRST) (M.I.)

Address: _____
(STREET AND NUMBER)

_____
(CITY, STATE, ZIP)

DOB: _____/_____/_____ Age: _____

Name of parents/guardians:

_____
(LAST) (FIRST) (M.I.)

_____
(LAST) (FIRST) (M.I.)

Cell Phone: (_____)_____ May I leave a message: _____

Home/other Phone: (_____)_____ May I leave a message: _____

Email: _____
*Please note by leaving your email address you are giving permission for email appointment reminders.

Please provide the following information for my records. Leave blank any question you would rather not answer, or would prefer to discuss with me in person. Information you provide here is held to the same standards of confidentiality as our therapy.

School Information:

School your child currently attends: _____
Current grade level: _____

Has your child ever been disciplined at school for his or her behaviors?
YES NO
If yes, please describe (ex: detention, suspension): _____
_____

What is your child's current academic standing?
( ) A ( ) B ( ) C ( ) Currently failing/danger in failing

TREATMENT HISTORY:

Has your child received mental health services in the past (ex: outpatient therapy, wraparound/BHRS, family based, psychiatric services): YES NO

If yes, please list therapist name/type of service/approximate dates:
_____
_____

Is your child currently taking prescribed psychiatric medication (antidepressants or others)? YES NO

If yes, please list:
_____
_____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION:

Please list your child's Primary Care Physician:
_____

How would you rate your child's current physical health?

( )Poor ( )Unsatisfactory ( )Satisfactory ( )Good ( )Very Good

Please list any specific health concerns (e.g. chronic pain, headaches, asthma, diabetes, etc.:
_____
_____

Is your child currently on medication to manage a physical health concern?
If yes, please list: _____

Is your child having any problems with sleep habits? YES NO
If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

How many times per week does your child exercise? _____

Is your child having any difficulty with appetite or eating habits? YES NO
If yes, check where applicable: ( ) Eating less ( ) Eating more
( ) Bingeing ( ) Restricting

Do you suspect your child is experimenting with alcohol? YES NO

Do you suspect your child is experimenting with recreational drugs?
YES NO
Has your child shared having suicidal thoughts recently? YES NO

Has your child shared having suicidal thoughts in the past? YES NO

Is your child experiencing any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Trouble with compliance/authority	Yes / No
Trouble with focus	Yes / No
Impulsivity/risky behaviors	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing)	Yes / No
Suicidal attempts	Yes / No If yes, when?

My child is:
( ) My full biological child ( ) Adopted and unaware of it
( ) Adopted and aware of it ( ) Other (please explain): _____
_____

Has your child ever witnessed domestic abuse? YES NO UNSURE
( ) Emotional ( ) Physical ( ) Verbal

Has your child ever experienced abuse or neglect? YES NO UNSURE
( ) Verbal ( ) Physical ( ) Emotional ( ) Sexual

If you are comfortable, please share any information regarding the abuse:
_____
_____
_____

Does your child typically get along well with same aged peers? YES NO
If no, please describe: _____
_____
_____

Is your child currently in a romantic relationship? YES NO

On a scale of 1-10 (10 being the highest quality), how would you rate your child's current relationship? _____

In the last year, has your child experienced any significant life changes or stressors? If yes, please explain: _____
_____
_____
_____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling, parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Obsessive Compulsive Disorder	Yes / No	

OCCUPATIONAL INFORMATION:

Is your child currently employed? YES NO
What is your child's job title? _____
Are you (child's parent/guardian) currently employed? YES NO
What is your job title? _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider your family to be religious or spiritual? YES NO
If yes, what is your family's faith? _____

Other Information:

Is your child currently on probation? YES NO
If yes, please describe: _____
_____
_____

What do you consider to be some of your child's strengths? _____
_____

What do you consider to be some of your child's limitations? _____
_____

What would you like to see your child accomplish in therapy? _____
_____
_____
_____
_____
_____

Please share any other information you would like the therapist to know:
_____
_____
_____
_____
_____
_____