Marel Grunt, LMFT
1138 Ballena Boulevard, Suite A2
Alameda, CA 94501
(510)703-9415
LMFT 52906

CHILD/ADOLESCENT HISTORY FORM

Please fill out this intake form as completely as possible. The questions below are designed to help me in our work together. All information is confidential as outlined in my Consent to Treatment form. If there are any questions that you do not wish to answer, please indicate this by writing "Do not wish to answer." Please print clearly and bring with you to our first session.

CHILD'S NAME: _____ Male/Female _____ Date: _____
DATE OF BIRTH: _____ AGE: _____
ADDRESS: _____
TELEPHONE: (Home/Cell) _____ (Work): _____
PARENT / GUARDIAN NAME(S): _____
HOME PHONE: (___)_____ (May I leave a message?)
CELL NO.: (___)_____(May I leave a message?)
EMAIL: _____
*Please note: Email correspondence is not considered to be a confidential means of communication.
REFERRAL SOURCE : _____
School: _____ Teacher: _____ Grade: _____
How does your child do in school academically?
_____
Behaviorally?
_____
Does your child have a physical or learning disability? Yes _____ No _____ Not sure _____
Does your child have a mental health diagnosis? _____

MEDICAL HISTORY:
During pregnancy, did mother use:
Cigarettes ___ Alcohol ___ Drugs ___ Experience a major stressor? _____
Specify frequency, amounts, and duration: _____
List any birth complications (Premature, C-section etc.): _____
List any medical conditions or history (Ex. broken bones, surgery, allergies etc.)
Does your child/Adolescent use: Cigarettes _____ Drugs ___ Alcohol ___
Specify amount and frequency: _____
Primary Care Physician: _____ Last seen on: _____
Psychiatrist: _____ Last seen on: _____
Current Medications (Include dosage and frequency):
_____
In the first two years did your child experience:
Separation from mother _____ Out of home care ___ Disruption in bonding _____ Neglect _____
Parental stress ___Depression of parent ___ Parental stress _____ Chronic pain or illness_____
If yes, please specify: _____
_____

DEVELOPMENT AND FAMILY HISTORY:

Reached developmental milestones: On time ____ Early ____ Late: ____
How many times has your child moved homes? _____
What five words best describe the relationship between your child/adolescent and...
Primary caregiver? _____
Co-parent: _____
Parent 1: _____ DOB: _____
Parent 2: _____ DOB: _____
Parents are: Married _____ Separated _____ Divorced: _____
Siblings:
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
What five words best describe the relationship(s) between your child/adolescent and his/her sibs?
_____
_____
Does anyone else live in the household? _____
Was your child adopted by either parent? Yes _____No: _____ If yes, when? _____
Who is the primary caregiver for this child? _____
Does the parent 1 work outside the home? Yes ____ No ____ Occupation _____
Hours _____ Parent 1 Level of Education: _____
Does the parent 2 work outside the home? Yes ____ No ____ Occupation _____
Hours _____ Parent 2 Level of Education: _____
If separated or divorced what is the visitation schedule? _____
What is the custody arrangement regarding physical and mental health care?
_____
Does either parent have legal issues? _____
List any history of mental illness or addiction in the immediate or extended family (ex. ADD, Depression, anxiety, bipolar disorder, suicide attempts, alcoholism, etc.)
_____
_____
Has your child ever witnessed domestic violence? Yes ____ No ____ If yes, please specify:
_____
How is your child disciplined? Please list each method and frequency of use:
_____
_____

TRAUMA HISTORY:

Has your child ever been verbally abused? Yes ____ No ____ Suspected ____
Please specify: _____
Has your child ever been physically abused? Yes ____ No ____ Suspected ____
Please specify: _____
Has your child ever been sexually abused? Yes ____ No ____ Suspected ____
Please specify: _____

Other stressors or trauma? _____
_____

CONCERNS:

Circle the symptoms your child/adolescent displays and list the number of times per week it is displayed:

Anger	Anxiety	Bed wetting
Acts out sexually	Conduct problems	Phobias
Controlling bowel movements/ urine	Hyperactivity	Disassociates actions
Has unusual sexual knowledge	Defiance	Depression/sadness
Suicidal thoughts	Lack of empathy	Lack of motivation
Lethargy	Low impulse control	Low self esteem
Hypervigilance	Isolation	Dishonesty
Nightmares	Plays out violent themes	Peer problems
Obsesses about small things	Over / under eating	Shyness
Sleeplessness	Running away	Stealing

Somatic symptoms (headaches/ stomach aches, etc)

How does your child/adolescent handle anger?

_____

Has your child/adolescent experienced significant loss? _____

_____

What do you see as your child/adolescent's major strengths and positive traits?

_____

_____

What are your child's/adolescent's responsibilities at home?

_____

_____

How well does your child/adolescent handle these responsibilities?

_____

Briefly explain your goals for your child's/adolescent's therapy:

1. _____
2. _____
3. _____

Is there anything else that you would like me to know?

_____
_____
_____
_____