Fairbanks Therapy Associates Inc.
helping to navigate life's journey
907-452-2473 f: 907-452-6903 PO Box 82842 Fairbanks, AK 99708
www.FairbanksTherapyAssociates.com &www.LEAPFbks.com
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Therapy Intake Child/Adolescent

Child's Name: __________________________________ Date of Birth: ___________Age: ___________________
Child's Address: ____Home Phone: __________________________
Child lives with: Both biological parents _____ Mother _____ Father _____ Mother & Stepfather _______
Father & Stepmother _____ Other (specify): ____
If parents are divorced, describe custody arrangements: ____
____

INFORMATION ABOUT CHILD'S MOTHER:
Mother's Name: _______________________________ Age: ___________ Race: __________________________
Employer: ____________________________ Occupation: ________________________ Hrs/wk: ______________
Can you be contacted at work by phone? Yes ______ No ______ Work Phone: _______________ Ext. __________
Religious Denomination: ____________________________________Church: ____________________________
Member? Yes ______ No ______ Active? Yes ______ No ______
Describe any physical problems you have that require medication or physical care:
____
Are you currently receiving medical treatment? Yes ______ No ______ Physician: _________________________
Medication(s) currently using:
____
Previous Counseling/Therapy? Yes ______ No ______ If yes, when? _____________________________________
With whom and for how long?
____

INFORMATION ABOUT CHILD'S FATHER:
Father's Name: _______________________________ Age: _______________ Race: ______________________
Employer: _______________________________ Occupation: ____________________ Hrs/wk: ______________
Employer's Address:
____
Can you be contacted at work by phone? Yes ______ No ______ Work Phone: _________________Ext. ________
Religious Denomination: ___________________________________ Church: ______________________________
Member? Yes ______ No ______ Active? Yes ______ No ______
Describe any physical problems you have that require medication or physical care:
____
Are you currently receiving medical treatment? Yes ______ No ______ Physician: __________________________
Medication(s) currently using:
____
Previous Counseling/Therapy? Yes ______ No ______ If yes, when? _____________________________________
With whom and for how long?
____

FAMILY MEMBERS:
List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime:
Name - Relationship to Child - Age - Highest School Grade Completed - Occupation
____
____
____
____
____

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Using the scale below, please indicate choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item. (You may add written comments after areas checked.

_____ Anger/Temper _____ Talks of Suicide _____ Depression _____ Unhappy Most of the Time
_____ Divorce/Separation of Parents _____ Use of Alcohol _____ Adjustment to Parent's Remarriage
_____ Use of Other Drugs _____ School Performance _____ Work _____ Family Problems _____ Worry
_____ Fearfulness _____ Self-esteem _____ Physical Problems _____ Poor Appetite
_____ Problems with Social Relationships _____ Overeating _____ Problems Sleeping _____ Bedwetting
_____ Sexual Concerns _____ Soiling _____ Religious/Spiritual Concerns _____ Cruelty to Animals
_____ Nightmares _____ Other (specify): ________________________

Have there been any previous psychological, psychiatric, neurological, or E.E.G. evaluations? Yes ____ No ______
If yes, please list names, addresses, and dates of contact:____
____

Has child had previous counseling? Yes ______ No ______ If yes, list names(s) of counselor(s), addresses, and dates of contact(s):____
____
____

Reason for contact:
____

MEDICAL HISTORY:

Where her any complications surrounding the child's birth? Yes _____ No _____ If yes, describe:____
____

List child's sicknesses, operation, and injuries. Indicate age when occurred, and describe how severe. Pleas pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:
____
____List current medical problems: ____
____

Is child currently taking any prescription drugs? Yes _____ No _____ If yes, please list: ________________________
____

When did your child last have a physical examination?____
Name of Physician: ___________________________ Address: ____
____
How is the child's vision? _________________________________Hearing? ________________________________

ACADEMIC/SCHOOL INFORMATION:

Name of school: ________________________________ Grade: __________ Teacher: ________________________
List previous schools attended with dates:
____
____
Has child ever repeated a grade? _____________ If so, which one(s)? ___________________________________

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How does your child get along at school?
____

Describe difficulties in learning at school:
____
____

Have other family members have learning difficulties?
____
____

Describe what your child likes to do for fun, special interests, hobbies, etc.
____

Describe your child's religious background (religious denomination is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.):
____

Anything else you think would be important for the counselor to know:
____
____

Any allergies or health issues or hospitalizations:
____
____

Has there ever been any involvement with OCS? ________________ if yes, please explain:
____
____

Custodial Parent/Guardian: ___________________________________ Date: ________________________

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PLEASE COMPLETE THE FOLLOWING: (To be completed by child/adolescent)

1. I would like

2. If I were older

3. Girls

4. My friends think

5. What makes me mad is

6. My father

7. I miss

8. I am scared

9. I often think of myself as

10. My only trouble

11. I dream of

12. Being younger would

13. I hate

14. If I don't get what I want at home

15. What worries me is

16. When I grow up

17. Nothing bothers me more than

18. Other people think I'm

19. I feel unhappy sometimes because

20. Boys

21. There are times when I

22. Being my age is

23. I don't think I can

24. It's tough when

25. At home

26. Teachers are

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27. If I am left behind

28. Sometimes I think about

29. If I were smarter

30. Sometimes I feel like

31. It is more important to

32. I wonder if I should

33. My mother

34. If my parents had only

35. I would be happier if

36. I'm glad I'm

37. I wish I were

38. If I could choose my family

39. If only I were not so

40. It would be funny if