ACTS Therapy LLC
8170 Old Carriage Court Suite 215, Shakopee, MN 55379
Phone: 612.483.4464; Fax: 952-465-3901
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CHILD & ADOLESCENT DEVELOPMENTAL HISTORY INTAKE FORM

Parents or Guardians: Please fill out one form per child

Child's Name: _____ D.O.B.: _____ Age:___

School:_____ Teacher:_____ Grade: _____

How does your child do in school academically? _____

How does your child do in school behaviorally?_____

Does your child have a learning or physical disability? __Y, __N, __Maybe.
Specify: _____

Does your child have a mental health diagnosis? __Y, __N,
Specify: _____

Does your family have an specific spiritual beliefs? _____

Child's residence: ___Biological parent's home ___ Relative's home ____Biological and step parent's home ___Foster Home ___ Adoptive Home

Parent's status: ___single, never married ___ married, when? ___
___ separated, when ? ___ ___ divorced , when ? ___
___ live-in partner, how long ? ___ ___ widow , when ? ___

CUSTODIAL PARENT HOME ADDRESS:_____
_____City:_____ State: ____ Zip:_____
E-MAIL: _____
Phone: H: _____W: _____ Cell:_____
Best number to reach you ___H ___W ___Cell ___other_____
Occupation: _____ Length of time at this position _____

NON-CUSTODIAL PARENT HOME ADDRESS (if applicable): _____
_____City:_____ State: ____ Zip:_____
E-MAIL: _____
Phone: H: _____W: _____ Cell:_____
Best number to reach you ___H ___W ___Cell ___other_____
Occupation: _____ Length of time at this position _____
If separated or divorced, visitation schedule: _____

Any Involvement with Child Protective Services? ___ Y ___ N
Describe:_____

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People in household: Siblings (list names and ages)_____
_____

Others (list name and relation to child) _____
_____

How many times has the child moved homes? _____

Does either parent have current legal involvement? _____

MEDICAL HISTORY
Primary Care Physician: _____ Phone:_____

Last seen on: _____ Reason for last visit _____

Current medications: (Include dosage and frequency)_____
_____

Allergies: _____
List any birth complications (Ex: Premature, jaundice, C-section, etc.)_____
_____

During pregnancy, did mother use:
__ Cigarettes, __ Alcohol, __ Drugs, __ Experience Extreme Stress?

Specify frequency, amounts, and duration: _____
_____

Milestones, what age did your child start to: Sit-up: _____ Crawl: _____
Walk: _____ Talk: _____ Toilet trained: _____
Reached developmental milestones: __On time, __Early, __Late

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)_____
_____
_____

Does child use: __ Cigarettes, __ Alcohol, __ Drugs
Specify amount and frequency: _____

Do you feel your child has a problem with drugs or alcohol? ___ Yes ___No

Has the child been in counseling before: ___Y ___N, Age (s):_____

Name of prior therapist and reason for treatment:_____
_____

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May I contact them? ___Y ___ N Phone _____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):
_____
_____

Has your child witnessed: domestic violence? __Y, __N,

Has your child ever experienced: verbal abuse? __Y, __N, physical abuse? __Y, __N
sexual abuse? __Y, __N, __Suspected. Specify_____
_____

Other stressors or traumas? _____
_____

Responsible Party for insurance _____
Company: _____Policy #_____

Referral source: _____

PERSONAL HISTORY
How does your child handle anger or change? _____
_____

Has the child experienced any significant loss? If yes, explain: _____
_____

What do you view as your child's major strengths and positive traits? _____
_____
What are your child's hobbies? _____

_____

Briefly describe your goals for your child's therapy: _____
_____

What are three adjectives that describe:
Mother: _____

Father: _____

Step parent: _____

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Child: _____

Parental Relationship: _____

Check any symptoms your child displays:
___ Anger ___ Anxiety ___ Bed wetting ___ Acts out sexually
___ Conduct problems ___ Controlling Day defecation ___ Running Away ___ Shy
___ Has unusual sexual knowledge ___ Plays out sexual themes ___ Peer problems
___ Day wedding ___ Defiance ___ Depression ___ Homicidal thoughts or actions
___ Drug or alcohol use ___ Hyperactivity ___ Masturbates excessively
___ Hyper vigilance ___ Isolation ___Lack of empathy ___Lack of motivation
___ Lethargy ___Low impulse control ___ Plays out violent themes ___ Sleeplessness
___ Low self-esteem ___ Lying ___ Nightmares ___Over/Under eating ___ Phobias
___ Stealing ___ Tantrums ___ Somatic Symptoms(Headaches/Stomachaches, etc).
Other: _____

How is your child disciplined? Please list each method and frequency of use:
_____
_____
_____
What goals would you like your child to work on in therapy?
_____
_____
_____
Please list any information you deem to be important for the therapist to know: _____
_____
_____
_____

THIS FORM COMPLETED BY: _____Date_____