Sparkman
Counseling & Educational Consulting
PLLC

Laura L. Sparkman, M.S, LPC, NCC

Child/Adolescent Intake Form
CONFIDENTIAL

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

*Name:*_____ *First Visit Date:*_____
Last First MI
Gender Identification: Male__ Female__ Other: _____
*Date of Birth*_____ *Age*_____
*Occupation:*_____ *Length of Time at this Job:*_____
Ethnicity:
African American___ Bi-racial___ Hispanic/Latino___
Asian___ Caucasian___ Native American___ Other_____

Primary language: English ___ Spanish ___ Other ___

CONTACT INFORMATION
Cell Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Home Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Work Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Best Time and Place to call:_____
Mailing Address:_____
Street City State Zip
May I correspond with you via mail at the above address: Yes No

In case of emergency, I authorize Laura Sparkman to contact:
_____
Name: Last, First Relationship Phone
Person responsible for financial arrangement: _____
Name: Last, First
Who referred you? (Please be specific): _____
May I contact this referral source to thank them for the referral: Yes No

Note: There will be a charge for all sessions not cancelled within 24 hours.

CURRENT CONCERNS

General reason(s) for seeking counseling services at this time:

_____

_____

_____

*Circle all items that you see as ongoing struggles in your life that you would like to work on in counseling

Issues Related to Abuse
Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment/rejection
Suspected sexual abuse
History of family domestic violence

Career/Academic Issues
Colleague/Cohort problems
Harassment issues
General work performance issues
Failing grades
Chronic stress
Career dissatisfaction
General problems at work/school

Mood-Related Concerns
Disturbing memories
Difficulty going to sleep/Staying asleep
Nightmares/Night terrors
Suicidal thinking or talking
Suicidal attempting
Sadness/Depression
Feelings of guilt and shame
Excessive worrying or fear

Family Relationship Concerns
Difficulty adjusting to family changes
Parenting/Discipline concerns
Parent-child relationship problems
Divorce
Separation
Religious/Spiritual Concerns
Estranged relationships
Constant fighting

Behavioral/Conduct Issues
Aggression toward others
Drug/alcohol use
Hyperactive/Impulsivity
Excessive computer use
Lying
Betraying relationships
Intentionally hurting animals
Fire-setting
Other unusual behaviors (please specify)_____

Other Behavioral Concerns
Sexual identity questioning
Sexual issues in general
Appetite/Eating concerns
Sleep problems
Time management concerns
Inattentive
Lonely
Bored with Life

Please place a star by the most significant issue

Other unusual behaviors or recent changes in your life:

_____

_____

Please briefly discuss the above behaviors you have concerns about:

_____

_____

_____

When did you first become concerned about these issues?

_____
_____

Why, at this point, have you decided to pursue counseling for the concern(s) above:

_____
_____

1. *Are you presently receiving counseling services elsewhere?* Yes No
2. *Have you ever seen a mental health professional (a psychologist, therapist, counselor, etc.*)? Yes No

    a. *Previous Mental Health Professional/Agency:*_____
    b. *Phone:*_____
    c. *Services Dates:*_____*(beginning-ending)*
    d. *Reason for seeking counseling services:*_____
    e. *Describe the outcome of the counseling experience:*_____
    _____
    _____

3. *Have you been hospitalized for mental health concerns?* Yes No
    a. *If yes, When:*_____ *Where:*_____
    b. *Reason:*_____

4. *Are you seeking services because you are a victim of a crime?* Yes No
    a. *Did it result in legal action?* Yes No *If yes, explain:*_____
    _____

5. *Are you seeking services for possible court advocacy (custody issues, abuse testimony, etc.)?* Yes No
    a. *If yes, please explain:*_____
    _____
    _____

6. *Are you currently on probation?* Yes No

7. *Have you ever been suicidal?* Yes No

If yes, please explain when and what happened:

_____
_____
_____

CURRENT LIVING ARRANGEMENTS

Family of origin ____ Single ____ Spouse/Partner ____ Roommate ____ Other ____

Marital Status:

Never married ____ Currently married ____ Divorced ____

History of learning issues/behavioral/conduct problems: Yes No
*If yes, please explain:*_____

History of addictions (alcohol/drug/substance abuse, gambling, sex, pornography, etc): Yes No
*If yes, please explain:*_____

History of family violence: Yes No
*If yes, please explain:*_____

History of criminal activity: Yes No
*If yes, please explain:*_____

History of protective order: Yes No
*If yes, please explain:*_____

History of eating disorders (anorexia, bulimia, binge eating, laxative use, pica-eating inanimate objects, etc.): Yes No
*If yes, please explain:*_____

History of self harming behavior (cutting, burning, etc.): Yes No
*If yes, please explain:*_____

GENERAL HOUSEHOLD INFORMATION

List the members in your household, beginning with the oldest member (include the child.)
How long in this current living situation? _____

Name	Age	Gender	Relationship to self (include half/step/etc.)

If divorced/separated, circle the number which best describes your relationship with your child's other parent.

Hostile		Frustrating		Friendly
1	2	3	4	5

When did the divorce/separation occur?_____
How often does the child see the other parent?_____
Describe the visitation schedule:_____
_____

PHYSICAL/MENTAL HEALTH HISTORY

Primary Care Physician

*Name:*_____ *Phone:*_____

*Address:*_____

*Date of last physical:*_____

Physical Disability: Yes No *(If yes, explain)*_____

Chronic Illness: Yes No *(If yes, explain)*_____

Terminal Illness: Yes No *(If yes, explain)*_____

Allergy History: Yes No *(If yes, explain)*_____

Hospitalization History (medical issues only)-please describe:

_____

_____

_____

_____

Have you ever seen a psychiatrist? Yes No

Are you currently seeing a psychiatrist? Yes No

(If yes, please list contact information):

*Name:*_____ *Phone:*_____

*Address:*_____

What diagnosis have you received from a medical professional (or previous mental health professional)? (Ex: ADD/ADHD, Anxiety, Depression, Bipolar Disorder, Schizophrenia, Personality Disorders, etc.)

_____

_____

_____

What medication(s) are you currently taking (including psychotropic and over-the-counter, etc.)?

Medication Dosage Reason

_____

_____

_____

_____

_____

History of health/physical/mental symptoms includes (circle all that apply):

Asthma	Dizziness	Panic Attacks
Amnesia of large parts of childhood after age 5	Hallucinations-Auditory	Nervous stomach
Bedwetting	Hallucinations-Vision	Neurological problems/exam
Bone/joint/muscle	Hallucinations-Tactile	Severe PMS
Chest pain	Severe Headaches	Serious over/under eating
Chronic Illness	Heart Palpitations	Shortness of breath without exertion
Developmental delay(s)	Hospitalization	Sleep problems
Chronic Diarrhea	Major accident	Sleep walking
Disability	Major Illness	Surgeries
	Memories/flashbacks	

*Please describe circled items:*_____
_____
*Daily exercise/physical activity habits:*_____
*Daily caffeine intake:*_____
*How would you describe your overall diet?*_____
*Average hours of sleep per night:*_____
*Are sleep patterns consistent?*_____

HISTORY OF LIFE STRESSORS

***Note your approximate age at the time of the occurrence of the following items:
Chronic illness of family member ____ Death of significant person ____ Domestic violence ____
Family member absent ____ *Explain:*_____
Family member's disability/major accident ____ *Explain:*_____
Family member's emotional problems ____ *Explain:*_____
Family member's suicide ____ *Explain:*_____
Child separated from parent ____ *Explain:*_____
Parent's divorce ____ Death of a pet ____ Difficult medical treatments ____
Natural Disaster ____ Sexual assault ____
Other trauma/experience(s) that may have impacted you significantly: ____
*Explain:*_____

I agree that the above information is accurate to the best of my ability. I also understand if I have any questions regarding the above questions, I may ask these questions at any time.

Client/Guardian Date

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