

# Rhonda Andrews LCSW

Individual, Child & Family Therapist

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## INTAKE EVALUATION

To be completed by Parent

### Identifying Information

Client's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Identified Gender: M \_\_\_\_\_ F \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Custodial Parent(s) Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Other Parent(s) Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

May we leave a message for you at home? Yes or No: \_\_\_\_\_

May we leave a message at work? Yes or No: \_\_\_\_\_

Grade In School: \_\_\_\_\_ School: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Others living in the home (Include name, birthdate, and relationship to client for each):

\_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_

Immediate family living outside the home (Include name, birthdate, and relationship to client):

\_\_\_\_\_, \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### Insurance Information

Name of insured: \_\_\_\_\_ Insured date of birth: \_\_\_\_\_

Address of insured person: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Relationship of client to insured person: \_\_\_\_\_

Insurance company: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance company address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Insurance identification number: \_\_\_\_\_ Group number: \_\_\_\_\_

Employer of insured person: \_\_\_\_\_

Secondary insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of secondary insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Secondary company address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Secondary identification number: \_\_\_\_\_ Group number: \_\_\_\_\_

Employer on secondary insurance: \_\_\_\_\_

**Patient or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

## Presenting Problem

Describe the child's problem(s) that brings you in for treatment:

Parent/family's goals for treatment:

### Check any of the symptoms that the child has been having:

(This space reserved for additional comments by clinician)

Depressed mood	<input type="checkbox"/>	Feels hopeless	<input type="checkbox"/>
Extreme sadness	<input type="checkbox"/>	Tearful/crying spells	<input type="checkbox"/>
Trouble concentrating	<input type="checkbox"/>	Memory problems	<input type="checkbox"/>
Change in sleeping habits	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>
Security blanket or object	<input type="checkbox"/>	Stuttering	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>	Thumb sucking	<input type="checkbox"/>
Change in eating habits	<input type="checkbox"/>	Weight/appetite changes	<input type="checkbox"/>
Problems getting along with family	<input type="checkbox"/>	Problems getting along with friends	<input type="checkbox"/>
Doesn't seem to enjoy usual activities	<input type="checkbox"/>	Feeling of extreme happiness	<input type="checkbox"/>
Trouble doing school work	<input type="checkbox"/>	Truancy	<input type="checkbox"/>
Feeling stressed	<input type="checkbox"/>	Irritable	<input type="checkbox"/>
Low self-esteem	<input type="checkbox"/>	Isolation/withdrawal	<input type="checkbox"/>
Perfectionism	<input type="checkbox"/>	Expresses feelings of guilt	<input type="checkbox"/>
Worries	<input type="checkbox"/>	Seems nervous	<input type="checkbox"/>
Feeling fearful	<input type="checkbox"/>	Sudden feelings of panic	<input type="checkbox"/>
Physical complaints of pain	<input type="checkbox"/>	Tense/uptight	<input type="checkbox"/>
Anger outbursts	<input type="checkbox"/>	Acting violently	<input type="checkbox"/>
Running away	<input type="checkbox"/>	Harm to animals	<input type="checkbox"/>
Has hurt or cut on themself	<input type="checkbox"/>	Fire setting	<input type="checkbox"/>
Thoughts of killing self	<input type="checkbox"/>	Thoughts of killing others	<input type="checkbox"/>

**History of Treatment****Yes No****Comments/Explanation**

Has the child been in treatment before?			Date(s): Who did they see?
Was treatment successful?			What happened?
Was the child's school/counselor part of the treatment?			What was the involvement? Name: Phone:
Has the child been prescribed any psychiatric medications?			Date(s): If yes, please describe:

**Psychological History****Yes No****Comments/Explanation**

Has the child witnessed violence?			
Has the child been traumatized or abused?			
Was the child a victim, victimizer, or both?			
Was there a dominance of big kids over little kids that organized the orphanage or home?			
Has there been any family crisis since the adoption? Loss of family member, marital separation, or divorce?			
Do you know of any mental health issues in the family of origin?			In what area(s)?
Is the child aggressive?			In what area(s)?
Does the child struggle with impulse control?			
How did/does this child attempt to keep safe?			
What are the child's experiences with loss (parents, caregivers, siblings, friendships)?			

**Developmental History****Yes No****Comments/Explanation**

Were there problems with the pregnancy or delivery of the child?			
Any initial problems with eating, sleeping, or crying spells (colic, nightmares)?			
Did the child demonstrate any difficulties or delays in walking, talking, toilet training?			

**School History****Yes No****Comments/Explanation**

Were there any problems when the child started school?			
When did the child start school?			
What problems have come up during the school years?			
What grades is the child getting?			
Describe any changes in the child's school performance:			
How does the child get along with his or her teachers?			
How does the child get along with his or her friends or peers in school?			

What are the child's favorite subjects or school activities
What subjects or activities does the child have problems with?

### Medical History

	Yes	No	Comments/Explanation
Has the child seen a doctor within the last year?			What was it for?  Doctor's name:                      Phone:
Did the medical exam indicate evidence of prenatal exposure to alcohol or drugs, or other toxins?			
Is the child taking any medications, prescription or over the counter?			What?
Were the physical needs met adequately?			
Does the child have any allergies?			
Does/has the child had any physical health conditions (including head injuries, traumatic injuries, serious illness)?			
Does the child have any problems sleeping?			
Does the child have any problems eating?			
Does the child have any problems toileting?			

### Attachment, Social History, and Family Functioning

Describe the child's relationship to the parents:
Describe the child's relationship to the siblings: Please list names and ages and relationship with all siblings.
Describe the child's temperament regardless of the circumstances:
What is the child's ability to regulate their emotions?
What has been the parent's own experience in the regulation of their own emotions?
What are the child's strengths?
What are the child's weaknesses?
What are the parent's strengths?
What are the parent's weaknesses?

Where there any early attachments?

When:

To Whom:

What preceded the break in attachment?

What developmental stage was the child at during each break of attachment?

Who has worked with the child's stress system before, i.e. teaching, comforting, calming, soothing?

What is weakening attachment now that could be avoided?

Where is the child more open to cueing that leads to attachment?

Where there parting instructions that were given to the child?

What is the child doing that diminishes family self-esteem?

How is the child culturally and ethnically perceived in their community?

How is the child's sense of self being strengthened as an ethnic/cultural minority member?

What did parents most hope for in their adoption experience?

Does the child seem to be gaining against a normal development curve, staying on curve, or maintaining a slower curve?