Amy Rostand Morris, LCSW, LLC
41 – A Lenox Pointe, NE
Atlanta, Georgia 30324
404 – 654 – 0313

CHILD & ADOLESCENT DEVELOPMENTAL HISTORY INTAKE FORM

Parents or Guardians: Please fill out one form per child. This information is private and confidential, as are all of our sessions. Please complete as much of this form as you can.

Client Information:

Patient Name: _____ Male/Female:_____

Today's Date:_____ Date of Birth: _____

Family Information:

Custodial parent information:

Names:_____

Address: _____

City, State: _____ Zip: _____

Phone numbers ***with area code*** Home: ( )_____

Work: ( )_____ Cell: ( )_____

Birth date: _____ Age: _____ Social Security Number: _____

Employer: _____

Position: _____For how long?_____

Education: _____

Non-custodial parent information (if applicable):

Name:_____

Address: _____

City, State: _____ Zip: _____

Phone numbers ***with area code*** Home: ( )_____

Work: ( )_____ Cell: ( )_____

Birth date: _____ Age: _____ Social Security Number: _____

Employer: _____

Position: _____For how long?_____

Education: _____

Parents' Status (please circle): single, married, separated, divorced, widow(er), live-in partner

Patient's Residence – please circle:

Biological parent's home, Relative's home, Foster Home, Adoptive Home

Child's Siblings (name and age):

_____

_____

_____

_____

Family History (include births, divorce, losses, transitions, remarriage, illness, moves, etc.):

_____

_____

_____

_____

_____

_____

_____

Medical and Health History:

Insurance:

Responsible Party Billing Information:

Name:_____

Address: _____

City, State: _____ Zip: _____

Phone numbers ***with area code*** Home: ( )_____

Work: ( )_____ Cell: ( )_____

E-mail: _____

Responsible Party Insurance Company: _____

Policy #_____ Group# _____

Occupation:_____Employer:_____

Employer Address:_____

Primary Care Physician:

Name:_____

Address: _____

City, State: _____ Zip: _____

Primary Care Physician's phone number: (_____) _____

Date of your most recent physical examination:_____

Emergency Contact: _____Phone:_____

Pregnancy and Birth:

Full term: Y N Complications during pregnancy and/or at birth:

_____

_____

_____

Describe family structure when baby was born:

_____

_____

_____

Milestones– Please indicate age:

Sat-up: _____ Crawled: _____ Walked: _____

Talked: _____ Toilet trained: _____

Describe delays or complications in any of these areas:

_____

_____

_____

Any major illness/surgeries?: Y N Ages: _____

Please describe the illness/surgeries:

_____

_____

_____

_____

_____

Has your child ever been ill or on medication(s)? Y N Ages: _____

Please describe illnesses/medication(s):

_____

_____

_____

_____

_____

Any psychiatric illness/hospitalizations? Y N Ages:_____

_____

_____

_____

_____

_____

Any traumatic event(s)?: Y N Ages: _____

Please describe:

_____

_____

_____

_____

_____

Any involvement with child protective services? Y N Ages:_____

Please describe:

_____

_____

_____

_____

_____

Any substance use/abuse/dependence? Y N Ages:_____

Please list names/amounts:

_____

_____

_____

_____

History of counseling: Y N Ages:_____

Please circle type of treatment:

Family Individual Group School Alateen Day treatment Hospital Other

Name of prior therapist(s) and reason for treatment:

_____

_____

_____

Would you like me to contact them? Y N

Substance abuse treatment: Y N Ages:_____

Please list facilities and dates:

_____

_____

_____

_____

Educational and Social History:

Current School: _____ Grade: ___ Teacher: _____

Did you child attend daycare or preschool? Y N Age Child Started: _____

Comments:

_____

_____

_____

Who was/were your child's primary caregiver(s) from birth to 3 years?

_____

_____

_____

Please describe your child/teen's overall school experiences, including
Typical grades, socialization, type of classes –special ed, gifted, etc. – hobbies,
transitions, changes:

1st – 5th Grade:

_____

_____

_____

_____

_____

School attended: _____

6th – 8th Grade:

_____

_____

_____

_____

_____

School attended: _____

9th and up:

_____

_____

_____

_____

_____

School atttended: _____

Describe your child/teen's challenges:

_____

_____

_____

_____

_____

Describe your child/teen's temperament:

_____

_____

_____

_____

_____

Describe your child/teen's successes and qualities:

_____

_____

_____

_____

_____

People your child/teen seems to trust and relate well with:

_____

_____

_____

_____

_____

Referral Source: _____

May I inform this person that you have consulted with me?_____

What kind of problem brings you to see me?

_____

_____

_____

_____

This form completed by:

_____

Patient Signature:_____Date:_____

Printed Name:_____

Parent Signature:_____Date:_____

Printed Name:_____

Parent Signature:_____ Date:_____

Printed Name:_____