Whiteside County Community Health Clinic **Child/Adolescent Behavioral Health Intake**

Child's Name: _____ **Date:** _____

Form completed by: _____ **Relationship to child:** _____

Reason for seeking behavioral health services:

_____

_____

_____

How long has this been a problem? _____

Where do these problems occur? ☐Home ☐School ☐Public places _____

What has been tried to resolve these issues? _____

Family/Household Information:

Name	Relationship to child	Lives with? Y/N	Visits? Y/N

Additional family/household comments:

DCFS/child welfare agency, if applicable*:	
Probation officer/location, if applicable*:	
Pediatrician/Clinic*:	
Current School*:	
Current Grade Level:	☐Individual Education Plan ☐504 plan

Has your child been diagnosed with any of the following?

☐Autism ☐Learning disability ☐Intellectual disability ☐Traumatic brain injury

☐Speech/language impairment ☐Visual impairment ☐Hearing impairment

Were there any concerns with early development? _____

Has your child has experienced any of the following:

☐Physical abuse ☐Emotional abuse ☐Sexual abuse ☐Exposure to domestic violence

☐Neglect ☐Witnessed violence ☐Other Trauma _____

☐Significant losses, changes or adjustments in the last year _____

Is your child involved with any extracurricular activities: ☐ School Clubs ☐Sports ☐Dance ☐Volunteering

☐Work ☐Church ☐Youth Group ☐Theater/Arts ☐ Other: _____

Additional information you want to share with your child's therapist:

Questions for your child's therapist?

**Authorization to Release Healthcare form must be signed to receive/disclose any information*