Anchored Vision:
Family Therapy Services, PLLC
Child/Adolescent Intake

Please provide the following information about your child:

Full Name: _____

Nick Name: _____

Birth Date: _____

By signing and dating this document, you are giving written verification and consent that you are the legal guardian of this child and requesting that Joseph Velazquez of Anchored Vision treat your child with applicable therapeutic services.

Legal guardian/parent Sign & date _____, _____

Legal guardian/parent Sign & date _____, _____

Therapist Sign & date _____, _____

Tell me about your child:
What does your child do that you like? What does he/she do that other people like?

What are your child's strengths?

What are your family's strengths?

1102 A ST / Suite 504 / Tacoma WA 98402 Phone: 206. 788. 5285

E-Mail: info@anchoredvision.org Web: anchorchedvision.org

Concerns:
What are your specific concerns at this time?

Treatment Goals:
What are your overall goals for treatment?

What would you like to see change FIRST and how much will things need to change for you to be satisfied?

Family History:
The name of the child's biological parents and/or step parents:

Mother: _____ Father: _____

Stepmother: _____ Stepfather: _____

Who are other household members living with your child?

Names	**Ages**	**Relationship to child**

Who are your child's significant others NOT living in their current household?

Names	**Ages**	**Relationship to child**

How would you and/or your spouse characterize your relationship with your child/ children?

Please describe any past counseling that either your child or any family member

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? If yes, please describe:

Education History:
Current School and Grade:

Phone: _____ Teacher's Name: _____

What does your child's teacher say about him/her?

IEP: Y / N

if yes, reason for IEP:

School Psych. Tests available? Y / N

Is client willing to sign ROI to attain copy of academic records including IEP? Y / N

Is client in resource classes? Y / N

If yes, which classes?

Attendance over last 12 months: ___ Attending ___ Not attending regularly___ Chronic truancy

Other schools attended:

Academic concerns?

Concerns with relationships with school staff?

Concerns with relationships with other students?

Suspensions and/or Expulsions. If yes, for what?

Other schools attended (including pre-school):

Has your child ever repeated a grade? If so which one(s)?

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

Fighting	Lack of friends	Drug/Alcohol	Detention
Suspension	Learning Disabilities	Poor attendance	Poor grades
Gang influence	Incomplete homework	Behavior problems	

Medical History:

What is the name of your child's primary care physician? _____

Address: _____ Phone: _____

Date of your child's last medical examination: _____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Was the Child's father active in the child's life during the pregnancy and in the first years of the child's life and development?

Has your child experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness		Other

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?

Any other concerns? Please use space below

Symptoms Checklist:

Please check any of the concerns or symptoms listed below that you feel your child is currently experiencing:

____ relationship problems
____ difficulties with family
____ difficulties with friends
____school problems
____ step-family problems
____ divorce issues
____ serious physical illness (self or family)
____ health concerns (self or family)
____ fatigue/low energy
____ death of family member or friend
____ anxiety/worry/nervousness
____ panic attacks
____ perfectionism
____ guilt/shame feelings
____ trouble sleeping
____ depressed mood/sadness
____ suicidal thoughts
____ self-injury
____ eating habits
____ Bullying/ getting bullied
____ anger/irritability/outbursts
____ mood swings
____ Screen/media Time
____ aggressive/violent behaviors
____ concern about alcohol/drug use
____ physical abuse of self (current or past)
____ verbal/emotional abuse (current or past)
____ anger/irritability
____ mood swings
____ loss of temper/outbursts
____ overindulgence
____ trouble with memory or concentration
____ confusion
____ much fantasy or daydreaming
____ hyperactivity/attention problems
____ headaches/stomach aches
____ sexual problems
____ sexual identity concerns
____ identity concerns
____ feelings of unreality
____ obsessive thoughts/excessive fears
____ unusual thoughts or perceptions
____ excessive energy
____ impulsive decisions or actions
____ difficulty trusting others
____ low self-esteem
____ avoidance of conflict
____ withdrawn, isolating
____ shy/uneasy around others
____ fear of failure
____ fear of disapproval
____ difficulty making independent decisions
____ feelings of futility/loss of hope
____ loss of joy in living
____ physical abuse of others
____ Problems at school or school/life balance.
____ physical abuse of self (current or past)
____verbal/emotional abuse (current or past)
____ loss of interest in previous activities
____ recurrent flashbacks
____ reluctant to leave home or familiar neighborhood
____ concerns about behavior/habits/ compulsions
____ concern about lying or dishonesty with others

Client/guardian

Legal guardian/parent Sign & date _____, _____

Legal guardian/parent Sign & date _____, _____

Therapist Sign & date _____, _____

_____