Restored Haven Counseling

9896 Bissonnet St Ste 455, Houston, Texas 77036
Kandys McKinley, MEd, LPC, LSOTP

Child/Adolescent Psychosocial Intake

(Please print clearly & fill in completely)

Today's Date:_____ Referring person or Agency:_____

Child's Name _____ Gender: M or F (circle)
Birth Date: _____Place of birth_____ Age: _____
Address: _____ City:_____ State: _____ Zip: _____
Home Phone: (_____)_____ Work phone: (_____)_____ Mobile: (___)_____
Grade Level _____ Present School_____

In order for us to treat a minor child (under the age of 18), we must have written consent of the child's parent(s) or legal guardian(s). Please indicate your consent for us to treat your child by signing the following statement: I,_____, state that I have the legal rights and authorize Johnson Behavioral Consulting to provide mental health services to _____(name of child), date of birth (DOB)_____ and to herewith authorize said services.

Parent Signature_____ Date_____

Chief Complaint:
Presenting problems: (check all that apply)

__Depressed
__Oppositional, resist, does not comply, negativitism
__Anger outburst or Rages
__Withdrawn
__Distractibility, inattentive, poor concentration, daydreams
__Fearful
__Developmental Delays – Walking, Reading
Toilet Training
__Hyperactive
__Fighting or Aggressive
__Difficulties with parents /new marriage /new family
__Impulsive
__Stubborn
__Disobedient
__Immature
__Mean to others or animals
__Destructive
__Legal difficulties
__Running away
__Self harming behaviors
__Head banging
__Rocking / Thumb sucking
__Shy
__Strange behavior
__Strange thoughts
__Fire setting
__Stealing
__Lying
__Sexual acting out
__School performance
__Truancy, failure in school, learning disabilities
__Eating problems
__Sleeping problems
__Distractible
__Lacks initiative
__Undependable
__Peer conflict
__Intense fears
__Always complains of feeling sick
__Suicide verbalizations
__Drug, Alcohol or Substance use

How long have these problems occurred? (number of weeks, months, years)._____

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Family Relationship:

Mother's Relationship to Child __Natural parent __Step-parent
__Relative __Adoptive-parent

Mother Name_____
Birthplace _____ Marital Status_____
Occupation_____Education_____

Father's Relationship to Child __Natural parent __Step-parent
__Relative __Adoptive-parent

Father Name_____
Birthplace_____ Marital Status_____
Occupation_____ Education_____

Siblings:

Name	Age	Describe Relationship

Child Medical Health History

Illness/Accidents	Age	Treatment Outcome

Current medical concerns:_____
_____
_____

Current Medications	Dosage	Frequency	Purpose

Has child ever been hospitalized? ___Yes __No

If yes, please explain: Age___ How long_____ Reason:_____
_____
_____

Name of Child's Primary Care Physician_____
Physician's Contact Telephone Number:_____

Mental Health History

Has your child had prior psychological, psychiatric, counseling, drug or alcohol services?

When	Where	Diagnosis	Treatment Provider	Treatment Outcome

Situation that led to today's visit:_____
_____

Areas you would like to see change in your child's life:_____
_____

***Insurance Information*: *Please have copy of insurance card available*.**

Insurance Carrier: _____Phone number: _____

Subscriber/Member ID Number:_____

Client is one of the following: __Subscriber ___Spouse __Child

Name of the insurance subscriber (primary): _____
DOB:_____ Insurance Authorization #_____