Talk-a-While
Child and Family Therapy Center PC

GROUP THERAPY INTAKE

PERSONAL INFORMATION:

Client's Name: _____ Date: _____
Date of Birth: _____ Age: _____
Gender Identity: □ Male □ Female □ Transgender □ Other: _____
Race/Ethnicity: _____
Religious Preference/Affiliation: _____
Client's School Name: _____
Client's Grade: _____

Talk-a-While Group Interested in Joining: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION:

Please list all the individuals whom currently live with your child/adolescent, including caregivers. Please also indicate if separate households.

Name	Age	Relationship	Occupation/Grade

CURRENT REASONS FOR SEEKING GROUP THERAPY PARTICIPATION:

Briefly describe the problem or reason(s) for which you or your child/adolescent are seeking to participate in group therapy. _____
_____
_____
_____

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What do you hope to gain from group therapy and what would you like to see happen as a result of this specific group therapy program?

_____
_____
_____

How important is this change for you? _____

CURRENT THERAPY/COUNSELING HISTORY:

Has your child/adolescent ever worked with a therapist, counselor, or participated in group therapy? □ Yes □ No
If yes, with whom did your child/adolescent work, what were the approximate dates of therapy, and the reason(s) your child/adolescent attended therapy and/or a group program?

_____
_____
_____

Has your child/adolescent ever been diagnosed with any specific medical and/or psychiatric condition(s)? □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____
_____

Does your child/adolescent currently take any medication(s) for any medical and/or psychiatric condition(s)? □ Yes □ No □ Unsure
If yes or unsure, please indicate what type and dosage. _____
_____
_____

What is the name of the physician or psychiatrist who is managing your child's/adolescent's medications?

_____

Physician's/Psychiatrist's Address: _____

Have teachers, school personnel, or any caregiver raised any concerns/complaints regarding your child/adolescent? □ Yes □ No
If yes, please explain. _____
_____
_____

SAFETY/RISK CONCERNS:

Has your child/adolescent ever purposely harmed himself/herself (e.g. cut, burned, bruised their body, or other)?
□ Yes □ No
If yes, please provide additional details. _____
_____
_____

Has your child/adolescent ever attempted suicide? □ Yes □ No
If yes, please provide additional details. _____
_____
_____

Has your child/adolescent ever been evaluated for danger to self, danger to others, or grave disability (5150 evaluation)? □ Yes □ No □ Unsure
If yes or unsure, please provide additional details (e.g. date(s) of evaluation(s), location, person whom completed evaluation).
_____
_____
_____

Has your child/adolescent ever been psychiatrically hospitalized for danger to self, danger to others, or grave disability (5150 Hold)? □ Yes □ No □ Unsure
If yes or unsure, please provide additional details (such as date(s) of hospitalization, reason for hospitalization, inpatient facility where they resided during this stay/multiple stays).
_____
_____
_____

Has your child/adolescent ever expressed thoughts of harming or killing others? □ Yes □ No
If yes, please provide additional details. _____
_____
_____

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Has your child/adolescent ever reported to you that they hear voices or see things that are not there? □ Yes □ No
If yes, please provide additional details. _____
_____
_____

PSYCHOSOCIAL HISTORY:

Family and Social Relationships

How does your child/adolescent behave or interact with you, their parent, guardian, or caregiver?
□ Poor □ Average □ Good □ Unsure

How does your child/adolescent behave or interact with their siblings?
□ Poor □ Average □ Good □ Does not apply

What are your child/adolescent's social skills with peers?
□ Poor □ Average □ Good □ Unsure

Family Events/Stressors
Is your family experiencing any of the following challenges at present? Or in the past? (Please check any that apply and indicate if past and/or present)

	Present	Past		Present	Past		Present	Past
Marital Problems	☐	☐	Custody Disputes	☐	☐	Financial Problems	☐	☐
Divorce/ Separation	☐	☐	Blended Family	☐	☐	Housing Problems	☐	☐
Death of Loved One	☐	☐	Serious Family Illness	☐	☐	Parent Alcohol/Drug Use	☐	☐
Parent Job Loss	☐	☐	Trauma	☐	☐	Other:	☐	☐

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Has your child/adolescent experienced any of the following in the past and/or present?

Psychological abuse (e.g. they were harshly yelled at, repeatedly "put down," victim of controlling behavior). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Physical abuse (e.g. they were hit, kicked, beaten up, or threatened to be hit).
□ Yes □ No □ Unsure. If yes or unsure, please explain. _____
_____

Sexual abuse (e.g. inappropriately touched, molested, assaulted). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Neglect (e.g. left unattended for extended periods of time, lacked clothing, food, were left soiled/dirty, failed to be provided needed medical/dental care or treatment).
□ Yes □ No □ Unsure. If yes or unsure, please explain. _____
_____

Witnessed violence at home (e.g. frequent verbal fighting, physical fighting, or sexual abuse among parents). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Interpersonal/dating violence. □ Yes □ No □ Unsure
If yes or unsure, please explain. _____

Bullying, cyber-bullying by peers and/or classmates, or victim of peer violence.
□ Yes □ No □ Unsure. If yes or unsure, please explain. _____
_____

Are there any firearms in your home? □ Yes □ No
If yes, how are they secured? Does your adolescent have access? Please explain.
_____
_____

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OTHER INFORMATION:

Child/Adolescent Strengths

Describe your child/adolescent's temperament/personality. _____
_____
_____

Describe your adolescent's strengths and unique qualities. _____
_____
_____

Is there any other information you would like us to know? _____
_____
_____
_____