Kuhn Behavioral Consulting Services
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Child / Adolescent Intake Document

This form has been designed to ask questions about you and your child's history and current symptoms and will provide useful information for your assessment and treatment. While it may be time consuming, please do your best to complete it fully, in any areas that are applicable to your child. If you feel uncomfortable completing any sections, feel free to leave them blank.

Once completed, please submit to KBCS in *one* of the following ways:

- Go to https://www.paubox.com/KBCS/upload and upload the form. Please type '*Last Name, First Name* – Intake Form' in the message box. Any information sent via this contact form will be encrypted for the security of clients.
- FAX: (808)356-1310
- EMAIL: info@kuhnbcs.com

Person Completing this Form

Name: ____

Please indicate relationship to the client: ☐ Parent ☐ Guardian ☐ Other: _____________

Are you authorized to consent for this individual's healthcare? ☐ Yes ☐ No

Basic Information

Child's Name: ____ DOB: __________________

Address: ____

City: ___________________________ State: ______________ ZIP Code: _______________

- -

Caregiver Name: ______________________________ Relationship: _________________

E-mail Address: _________________________ Home Phone: _______________________

Mobile Phone: __________________________ Approve Text Messages: ☐ Yes ☐ No

Best Contact: ☐ Home ☐ Mobile ☐ Text ☐ Email

Caregiver Name: ______________________________ Relationship: _________________

E-mail Address: _________________________ Home Phone: _______________________

Mobile Phone: __________________________ Approve Text Messages: ☐ Yes ☐ No

Emergency Contact Name / Relation: ____

Emergency Contact's Number: ____

- -

Primary Insurance Carrier: ______________________________

Insurance Type: ☐ Commercial ☐ Medicaid

Insurance Number (For Tricare, please provide Sponsor SSN): ____________________________

Insurance Sponsor Name: ____

Secondary Insurance Carrier (if applicable): ______________________________________

Secondary Insurance Type: ☐ Commercial ☐ Medicaid

Secondary Insurance Number: ________________________________

Secondary Insurance Sponsor Name: ____

Family History

The name of the child's biological parents:

Mother: ____ DOB: __________________

Father: ____ DOB: __________________

Who has legal guardianship of your child? ____

Any family legal issues? ____

Primary Language: □ English □ Other: specify _______________

Percent time child is exposed to non-English language(s): _________%

Who does your child currently live with?

Names	Ages	Relationship to child
____	_________	_________________________
____	_________	_________________________
____	_________	_________________________
____	_________	_________________________
____	_________	_________________________

Who are significant people in your child's life that do NOT life with him/her?

Names	Ages	Relationship to child
____	_________	_________________________
____	_________	_________________________
____	_________	_________________________
____	_________	_________________________

History of Prior Residences outside of current state:

Has anyone in your family ever been diagnosed with a mental health disorder or has experienced mental health challenges? If yes, what relation are they to your child and what was there identified mental health diagnosis?

Please list any spiritual or cultural customs or traditions that may be important for the therapist to know:

Any current community resources that you are involved in? (Church, family groups, sports, etc)

Physical History

Name of your child's medical doctor: ____

Address: ____

City: ____________________________ State: ______________ ZIP Code: _______________

Phone: ___________________________________

Date of your child's last medical examination: _____________________________________

Were there any problems or complications during the pregnancy or at delivery? If so, please describe them:

Did your child have any delays in reaching developmental milestones? Please estimate when your child gained these skills.

Talking: ____

Walking: ____

Toilet Training: ____

Has your child experienced any of the following medical problems: *check all that apply*

☐ Serious accident
☐ Hospitalization
☐ Surgery
☐ Asthma
☐ Head injury
☐ High fever
☐ Convulsions/seizures
☐ Allergies
☐ Eye/ear problems
☐ Meningitis
☐ Hearing problems
☐ Loss of consciousness

Is your child taking any medication: ☐ Yes ☐ No

If yes, what kind: ____

Reason for medication: ____

For how long: ____

Prescribing Doctor: ____

Has your child ever been hospitalized for a physical illness: ☐ Yes ☐ No

If yes, please describe: ____

Has your child ever been hospitalized for a mental illness: ☐ Yes ☐ No

If yes, please describe: ____

Any recent major illnesses or surgeries: ☐ Yes ☐ No

If yes, please describe: ____

Any allergies: ☐ Yes ☐ No

If yes, list adverse reactions: ____

Any drug allergies: ☐ Yes ☐ No

If yes, list adverse reactions: ____

Any recurrent or chronic condition: ☐ Yes ☐ No

If yes, please describe: ____

(Children over age 12)
Does your child smoke: ☐ Yes ☐ No

If yes, how much/ often: ____

Does your child take drugs: ☐ Yes ☐ No

If yes, what kind: ____

Does your child drink: ☐ Yes ☐ No

If yes, how much/ often: ____

Education History

Name of School child attending: ____

Address: ____

City: __________________________ State: _____________ ZIP Code: ______________

Phone: ___________________ Teachers Name: _______________________________

Current Grade: ___________ School Hours (ex. 7:45 – 2:10): ___________________

IEP/504 plan: ☐ Yes ☐ No ***If Yes, Please include copy at the bottom of form***

History of other schools attended (including Pre-school):

Has your child ever repeated a grade: ☐ Yes ☐ No If yes, which grade(s): __________

Has your child ever received speech, occupational or physical therapy services in school: ☐ Yes ☐ No

Has your child experienced any of the following problems at School: *check all that apply*

☐ Fighting
☐ Drug/alcohol
☐ Detention
☐ Few friends
☐ Suspension
☐ Learning disabilities
☐ Other: ________________________
☐ Poor attendance
☐ Poor grades
☐ Bullying
☐ Gang influence
☐ Incomplete homework
☐ Behavior problem

Psychological History

Name of child's psychologist/psychiatrist: _______________________________________

Address: ____

City: __________________________ State: _____________ ZIP Code: ______________

Phone: ________________________ Email or Fax: ____________________________

Date of your child's last examination: _____________________________

Current DSM-5 Diagnosis: _____________________________

Diagnosing Physician: _____________________________

Date of Diagnosis**:** _____________________________

Any Previous Therapy/Counseling: ☐ Yes ☐ No
If yes, describe, when, where, how long, what for:

Any Previous Psychological testing: ☐ Yes ☐ No
If yes, describe:

Any Previous ABA services: ☐ Yes ☐ No
If yes, describe:

Any Speech/Occupational/Physical therapy services outside of school: ☐ Yes ☐ No
If yes, describe:

Any display of attempts to harm self or others: ☐ Yes ☐ No
If yes, describe:

Any display of sexual acting out: ☐ Yes ☐ No
If yes, describe:

What do you hope to gain from this assessment / treatment plan?

Note: If your child has been previously evaluated, please provide a copy of the report.

Preferred items/Reinforcers

What are areas of strengths for your child?

Please list any items that your child enjoys or is passionate about.

Current Skill Level

Communication:

Your child's main form of communication:

☐ Gestures
☐ Words
☐ Other: ___________________________
☐ Sign language
☐ Augmentative communication device

Please provide any other information you would like us to know about your child's communication.

Social skills:

Does you child independently interact with peers: ☐ Yes ☐ No

Describe your child's current strengths socially:

Describe your child's current weakness socially:

Please provide any other information you would like us to know about your child's social skills.

Self-Help Skills:

Is your child able to dress him/herself without help: ☐ Yes ☐ No

Is your child able to bath or shower independently: ☐ Yes ☐ No

Does your child have any issues with sleep: ☐ Yes ☐ No

Does your child have any issues with meal time or food variety: ☐ Yes ☐ No

Please provide any other information you would like us to know about your child's self-help skills.

Problem Behaviors

What events typically trigger problem behaviors (some examples may be asking them to complete a task, telling them they cannot have a toy or activity, periods of low attention when they need to entertain themselves)?

What do the behaviors typically look like (some examples may be crying, laying on the floor, hitting, kicking, yelling, throwing items, head banging)

How long to these behaviors typically last?

How many times per week does your child typically engage in problem behaviors?

Does your child engage in any self-injurious behaviors?

What skills or behaviors are most important to you and your family to target during services?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Do you have any worries or concerns about moving forward with assessment / treatment? ☐ Yes ☐ No

If yes, please describe:

Hours of Availability

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

I understand that it is important to provide accurate information in order to tailor treatment and assessment to meet my child's needs. This information is correct as I have described it.

____

PRINT NAME of Parent/ Guardian/ Caregiver

____ ________________

SIGNATURE of Parent/ Guardian/ Caregiver **DATE**

Please attach a copy of your child's reports (please include all that apply):

☐Diagnostic Evaluation Report
☐IEP/IFSP/504 Plan
☐Functional Behavior Assessment (FBA) /Behavior Intervention Plan (BIP)
☐Prescription for ABA
☐Mental health directives
☐Medical advance directives
☐Powers of attorney
☐Discharge summaries or evaluations from all inpatient/outpatient services within the last 5 years

PLEASE USE THIS AREA TO TYPE ANY ADDITIONAL INFORMATION THAT YOU FEEL MAY BE HELPFUL. THANK YOU