

**Adoption Related Services of Pinellas**  
**8800 49<sup>th</sup> Street N. Suite 212 ♦ Pinellas Park, FL 33782**  
**Fax: (727) 865-5178**

**INTAKE INFORMATION**

Person Completing Form: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
 Cell Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 Emergency Contact (Name and Phone Number): \_\_\_\_\_

**Family Information** (List all family members living in the home. If there is not enough room, please continue on back):

Name	Relationship to Child	Date of Birth	Employer or School/Grade

**Placement History** (list all of client's placements, from birth to present. If there is not enough room, please continue on back):

Place of Residence	Dates	Person(s) Resided with

**Treatment History** (List any previous mental health treatment. If there is not enough room, please continue on back):

Agency	Dates of Treatment	Reason

List any family history of mental health diagnoses (specify relationship to child and diagnosis): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any family history of substance abuse (specify relationship to child and substance): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Intake Information

**Medication History** (List all current and past medications. If there is not enough room, please continue on back):

Medication	Dosage/Frequency	Dates

List any adverse reactions, ineffective medications or medication allergies (if none, please state "none"): \_\_\_\_\_

**Developmental History:**

Was the pregnancy with child planned?  Yes  No  Unknown

While pregnant, did the mother smoke?  Yes  No  Unknown If yes, what amount? \_\_\_\_\_

While pregnant, did the mother use drugs or alcohol?  Yes  No  Unknown

If yes, type and amount? \_\_\_\_\_

While pregnant, did the mother have any medical or emotional difficulties?  Yes  No  Unknown

If yes, list: \_\_\_\_\_

Length of pregnancy:  Premature  Full Term  Unknown Birth Weight: \_\_\_\_\_

Type of Delivery:  Spontaneous Vaginal  Induced Vaginal  C-Section  Unknown

Describe any physical or emotional complications with the delivery: \_\_\_\_\_

Describe any complications for the mother or the baby after the birth (including post-partum depression or chronic pain that was difficult to alleviate such as ear infections or colic): \_\_\_\_\_

List any congenital conditions or handicaps: \_\_\_\_\_

Is child adopted?  Yes  No If yes, age of child when adoption occurred: \_\_\_\_\_

Developmental Milestone	Age Achieved	Developmental Milestone	Age Achieved
Sat Alone		Weaned	
Crawling		Fed Self	
Took first step		Dressed Self	
Said first word		Toilet Trained	
Spoke in sentences		Tied shoes	

**Medical History:**

Primary Care Physician: \_\_\_\_\_ Most recent physical exam date: \_\_\_\_\_

Results of physical:  Normal  Abnormal

List any abnormal findings: \_\_\_\_\_

List any known medical problems: \_\_\_\_\_

List any known allergies: \_\_\_\_\_

Describe any hospitalizations, surgeries or accidents: \_\_\_\_\_

Intake Information

**School Information:**

Name of School: \_\_\_\_\_

Current grade: \_\_\_\_\_ List any grades repeated: \_\_\_\_\_

Child performs  Above grade level  At grade level  Below grade level

Are there any learning difficulties?  Yes  No If yes, list: \_\_\_\_\_

Are there any behavior problems at school?  Yes  No If yes, list: \_\_\_\_\_

How does client get along with peers: \_\_\_\_\_

Has IQ testing been completed?  Yes  No If yes, IQ score: \_\_\_\_\_

**Strengths/Positive Qualities:**

\_\_\_\_\_  
\_\_\_\_\_

**Substance Abuse History (Age 12 and over):**

Has child ever smoked cigarettes?  Yes  No If yes, state duration, frequency, & amount: \_\_\_\_\_

Has child ever used alcohol?  Yes  No If yes, state duration, frequency, & amount: \_\_\_\_\_

Has child ever used illicit drugs, prescription drugs or over the counter drugs?  Yes  No If yes, state duration, frequency, & amount: \_\_\_\_\_

**Reason for Seeking Treatment:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Relevant Information Not Listed on Intake Form:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_