

**LIGHT OF HOPE COUNSELING SERVICES, INC**

**Kiana Kalaghichian, LCSW**

**Business Address: 108 Orange Street, Suite 8, Redlands, CA 92373**

**1128 E. Sixth Ave, Suite 8, Corona, CA 92879**

**Phone: (951) 288-9086**

**Fax: (909) 363-8020**

**ADOLESCENT/ CHILD INTAKE FORM**

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Sibling: \_\_\_\_\_ Age: \_\_\_\_\_

Sibling: \_\_\_\_\_ Age: \_\_\_\_\_

Sibling: \_\_\_\_\_ Age: \_\_\_\_\_

**1. Parent's Name (mother/guardian):** \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Male/Female: \_\_\_\_\_

Phone: H( ) \_\_\_\_\_ W( ) \_\_\_\_\_ C( ) \_\_\_\_\_

Emergency contact: \_\_\_\_\_

**2. Parent's Name (father/guardian):** \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Male/Female: \_\_\_\_\_

Phone: H( ) \_\_\_\_\_ W( ) \_\_\_\_\_ C( ) \_\_\_\_\_

Emergency contact: \_\_\_\_\_

**3. Step Parent(s)** \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

***LIGHT OF HOPE COUNSELING SERVICES, INC***

***Kiana Kalaghichian, LCSW***

***Business Address: 108 Orange Street, Suite 8, Redlands, CA 92373***

***1128 E. Sixth Ave, Suite 8, Corona, CA 92879***

***Phone: (951) 288-9086***

***Fax: (909) 363-8020***

Male/Female: \_\_\_\_\_

Phone: H(\_\_\_\_)\_\_\_\_\_ W(\_\_\_\_)\_\_\_\_\_ C(\_\_\_\_)\_\_\_\_\_

Emergency contact: \_\_\_\_\_

**History of Problem**

Please describe what concerns you have regarding your child: \_\_\_\_\_

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

How long has the problem existed? \_\_\_\_\_

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

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years? \_\_\_\_\_

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

What attempts have been made to resolve the difficulties? \_\_\_\_\_

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

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Yes \_\_\_\_ No \_\_\_\_

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

***LIGHT OF HOPE COUNSELING SERVICES, INC***

***Kiana Kalaghichian, LCSW***

***Business Address: 108 Orange Street, Suite 8, Redlands, CA 92373***

***1128 E. Sixth Ave, Suite 8, Corona, CA 92879***

***Phone: (951) 288-9086***

***Fax: (909) 363-8020***

What do you consider to be some of your child's strengths? \_\_\_\_\_

---

---

---

What do you consider to be some of your child's weaknesses? \_\_\_\_\_

---

---

---

What would you like your child to accomplish during their time in therapy? \_\_\_\_\_

---

---

---

Please check the symptoms that the child is currently experiencing, as well as duration, and severity.

<b><i>Symptom Name(s):</i></b>	<b><i>How Long?</i></b>	<b><i>Severity of symptoms (None, Mild, Moderate, Severe)</i></b>
Sadness or Depression	_____	_____
Suicidal Thoughts	_____	_____
Sleep Problems	_____	_____
Change in Appetite	_____	_____
Weight change	_____	_____
Inability to concentrate	_____	_____
Obsessive thoughts	_____	_____
Tension and Anxiety	_____	_____

**LIGHT OF HOPE COUNSELING SERVICES, INC**

**Kiana Kalaghichian, LCSW**

**Business Address: 108 Orange Street, Suite 8, Redlands, CA 92373**

**1128 E. Sixth Ave, Suite 8, Corona, CA 92879**

**Phone: (951) 288-9086**

**Fax: (909) 363-8020**

Panic Attacks	_____	_____
Memory Problems	_____	_____
Compulsive Behaviors	_____	_____
Feelings of Hostility	_____	_____
Acts of Violence	_____	_____
Social Isolation	_____	_____
Strange Thoughts	_____	_____
Stomach Aches	_____	_____
Head Aches	_____	_____
Bed Wetting	_____	_____
Phobia	_____	_____

**Parent Information**

Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, etc)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is ex-spouse (biological parent) aware that you are bringing their children to therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

***LIGHT OF HOPE COUNSELING SERVICES, INC***

***Kiana Kalaghichian, LCSW***

***Business Address: 108 Orange Street, Suite 8, Redlands, CA 92373***

***1128 E. Sixth Ave, Suite 8, Corona, CA 92879***

***Phone: (951) 288-9086***

***Fax: (909) 363-8020***

If not, please explain. \_\_\_\_\_

\_\_\_\_\_

If adopted, does child know of adoption? Yes \_\_\_ No \_\_\_

What age was your child at the time of the adoption? \_\_\_\_\_

**Biological Mother's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Significant medical problems: \_\_\_\_\_

Current and past psychiatric treatment or counseling: \_\_\_\_\_

History of alcohol/drug use? \_\_\_\_\_

History of arrest? \_\_\_\_\_

**Biological Father's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Significant medical problems: \_\_\_\_\_

Current and past psychiatric treatment or counseling: \_\_\_\_\_

History of alcohol/drug use? \_\_\_\_\_

History of arrest? \_\_\_\_\_

**Child and School Information:**

Child lives with: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

History of psychiatric treatment or counseling: \_\_\_\_\_

Current or past drug or alcohol use (indicate past or present amount, frequency) \_\_\_\_\_

\_\_\_\_\_

Significant medical problems: \_\_\_\_\_

Serious illnesses, accidents, or surgeries in the past: \_\_\_\_\_

\_\_\_\_\_

Medications currently prescribed: \_\_\_\_\_

Pediatrician: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_

