Nurturing Life Concepts, LLC
Wendy A. West Pidkaminy, LCSW-R
Executive Officer
8195 Cazenovia Road, Suite 9
Manlius, NY 13104
(315) 682-4005
www.nurturinglifeconcepts.com

Child and Adolescent Demographic (Intake) Form

Today's Date ___/___/_____
Child's Name DOB Age
School Grade
Home Address:
Phone : Home ( ) ________________ Cell ( ) _________________
Email:

Parent or Guardian 1
Name (First, Middle Initial and Last)
Social Security Number DOB Age
Residential Address:
Home Phone: Cell Phone: Work Phone:
Email address:
May we email, text and or leave messages? NLC will never include any personal or clinical information in such messages, unless the correspondence was initiated, authorized or requested to do so by you. NLC may contact you about missed or rescheduled appointments. Anyone who reads such information or listens to telephone messages would realize that you have come to see NLC for services. Also note that text and email correspondence is vulnerable to interception and is not considered reliably confidential. Know that you are sending info in this manner at your own risk.
You may email me at the following email address:
You may text and or call the following phone number:

Gender: M F T		
Education Level:		
Marital Status: Married Separated Remarried Divorced Widowed In a relationship other		
Currently Employed or attending school: Y N Employer/School:		
Position Held:	Length of Time:	
Work Address:	Work Phone:	

Parent or Guardian 2		
Name (First, Middle Initial and Last)		
Social Security Number	DOB	Age
Residential Address:		
Home Phone:	Cell Phone:	Work Phone:
Email address:		
May we email, text and or leave messages? NLC will never include any personal or clinical information in such messages, unless initiated, authorized or requested to do so by you. NLC may contact you about missed or rescheduled appointments. Anyone who reads such information or listens to telephone messages would realize that you have come to see NLC for services. Also note that text and email correspondence is vulnerable to interception and is not considered reliably confidential. Know that you are sending info in this manner at your own risk.		
You may email me at the following email address:		
You may text and or call the following phone number:		
Gender: M F T		
Education Level:		
Marital Status: Married Separated Remarried Divorced Widowed In a relationship other		
Currently Employed or attending school: Y N Employer/School:		

Position Held:	Length of Time:
Work Address:	Work Phone:

Immediate Family Relationships/Family Constellation (spouse, children, siblings, parents etc) List each person Name: Relationship Age Location (ie live with you etc)

____
____
____
____
____
____
____
____

If parents are not living in the same home:
My child lives primarily with: Mother Father Other:
We are currently: Separated Never Married Divorced
My child has contact with the other parent. YES NO
Please explain the custody arrangement:

Reason for Today's Visit

____
____
____
____
____
____
_____

Symptoms Checklist: Check off if your child or teen is CURRENTLY experiencing any of the following:

- Thoughts of Harm to Self
- Thoughts of Harming Others
- Psychiatric Problems
- Irrational Fears
- Learning Disabilities
- Probation/Delinquent/Arrest
- Adopted/Foster Child
- Unpredictable Mood
- Substance Use
- Substance Abuse
- Constant Worry
- Sleep Problems
- Social Difficulties
- Work/School Difficulties
- Eating Disorders
- Self-Abuse
- (cutting, harming self)
- Nightmares
- Inappropriate with peers
- Behavior Problems
- Lying, Stealing
- Physical Pain
- Anxiety
- Poor Appetite
- Depression
- Suspected Eating Disorder
- Aggressive Behavior
- Few or No Friends
- School Problems
- Withdrawn/Shy
- Self-Critical, Perfectionist

Other ____

Recent environmental changes (over past year):

- Move to new home
- Move to new school
- Divorce of parents
- Remarriage
- Blended family issues
- Loss of a loved one

Please explain in detail

____

____

____

____

____

____

How many days a week does these problems occur? _____________ NOT occur? __________

Child/Teen Medical History: (include current medications (prescribed, OTC, and supplements), hospitalizations, medical diagnoses/procedures, allergies, smoking history,

caffeine intake, alcohol and drug use/abuse and exercise habits:

____
____
____
____
____
____
____
____

Child/Teen Significant Psychiatric History/Current Treatment Y N If YES, please explain

____
____
____
____
____

Family History: (history of trauma or violence, incarcerations, drug and/or alcohol abuse, gambling addiction, psychological/medical concerns in family members, social supports, etc…)

____
____
____
____
____
____

Significant Prenatal History: N/A or Yes
(include birth trauma, pregnancy, birth defects, congenital disorders, etc.)

____

____

____

____

____

Significant Developmental History: N/A or Yes
(atypical development including toileting, crawling, walking, talking, social development)

____

____

____

____

____

Special Needs: (Check all the apply)

- ___ IEP/504
- ___ Prosthesis
- ___ Fine motor
- ___ Learning Disabilities
- ___ Hearing
- ___ Information Processing
- ___ Glasses
- ___ Gross motor
- ___ Allergies

If above checked please describe:____

My Child can be best described as (Check all the apply)

- ___ Intelligent
- ___ Friendly
- ___ Shy
- ___ Busy
- ___ Anxious
- ___ Kinesthetic/physical
- ___ Fun
- ___ Creative
- ___ Spirited
- ___ Intense
- ___ Spontaneous
- ___ Quiet
- ___ Wise
- ___ Precocious
- ___ Organized
- ___ Independent
- ___ Dramatic
- ___ Consistent
- ___ Focused
- ___ Imaginative
- ___ Talented
- ___ Thoughtful
- ___ Excitable
- ___ Assertive

My Child best learns by: Hearing Seeing Doing Following Others

The three things that concern me the most are:

1) ____

2)

3)

What are your child or teen's personal skills, strengths and abilities:

The three goals that I have for this process are:

1)

2)

3)

Please list anything that was not asked that you feel is pertinent here: