Please mail or fax to:
2130 Green Bay Rd, Evanston, IL 60201
Phone: 847-425-9708 Fax: 847-448-8337

Client Registration Packet- Child/Adolescent: Today's Date: _____

Client Name _____ Nickname _____ Date of Birth _____ /_____ /_____

Gender _____ (examples: man, woman, nonbinary) Pronouns _____ (examples: she, they, he) Sexual orientation _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Can I leave a message? Home ☐ Y ☐ N Work ☐ Y ☐ N Cell ☐ Y ☐ N

Email _____ Fax (_____) _____

Parent / Guardianship Information

Legal Guardian _____ Relationship _____

Address (if different) _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Referral Information

Referred by _____ Referral Contact Phone (_____) _____

Referral E-mail _____ May ITA Contact the Referral? ☐ Y ☐ N

I, _____, grant my permission for ITA to contact my referral source, if possible, to acknowledge and thank them for the their referral. I understand I will not be identified in any way through this contact. _____(initial here)

Billing Information

Billing Name _____ Relationship to Client _____

Address (if different than above) _____

City _____ State _____ Zip _____ Primary Phone (_____) _____

Payment Type: ☐ BCBSIL ☐ Other Insurance ☐ Self Pay ☐ Financial Aid

Insurance Information

Name of Policy Holder _____ Insurance Company _____

Policy Number _____ Group Number _____

Emergency Information

Contact Name _____

Relationship to Client _____ Primary Phone (_____) _____

Primary Care Physician _____ Phone (_____) _____

Psychiatrist/Therapist _____ Phone (_____) _____

Presenting Issue

Please describe the reasons the client is seeking services: _____

_____

_____

_____

_____

Please check the symptoms the client has experienced recently:

Symptom	2 Weeks	6 Months	Symptom	2 Weeks	6 Months
Anxiety	☐	☐	Hypersomnia	☐	☐
Excessive Worry	☐	☐	Fatigue	☐	☐
Restlessness	☐	☐	Excessive Guilt	☐	☐
Concentration Issues	☐	☐	Worthlessness	☐	☐
Irritability	☐	☐	Suicidal Thoughts	☐	☐
Flashbacks	☐	☐	Homicidal Thoughts	☐	☐
Intrusive Thoughts	☐	☐	Distractibility	☐	☐
Nightmares	☐	☐	Impulsive Sexual Behaviors	☐	☐
Difficulty Falling Asleep	☐	☐	Truancy	☐	☐
Difficulty Staying Asleep	☐	☐	Stealing	☐	☐
Hypervigilance	☐	☐	Lying	☐	☐
Anger Outbursts	☐	☐	Mood Swings	☐	☐
Lack of Interest in Activities	☐	☐	Delusions	☐	☐
Social Isolation	☐	☐	Hallucinations	☐	☐
Detachment	☐	☐	Communication Problems	☐	☐
Heart Palpitations	☐	☐	Fine Motor Issues	☐	☐
Sweaty Palms	☐	☐	Gross Motor Issues	☐	☐
Difficulty Breathing	☐	☐	Sensory Processing Issues	☐	☐
Panic Attacks	☐	☐	Verbal Articulation Issues	☐	☐
Repetitive Behaviors	☐	☐	Behavioral Issues	☐	☐
Obsessive Thoughts	☐	☐	Defiance Issues	☐	☐
Depressed Mood	☐	☐	Academic Issues	☐	☐
Weight Loss	☐	☐	Emotional Dysregulation	☐	☐
Weight Gain	☐	☐	Other _____		
Insomnia	☐	☐			

Has the client received a diagnosis for these symptoms? _____

_____ Date_____

Was an evaluation conducted? ☐ Y ☐ N

Location of evaluation _____

Diagnosing Clinician _____

Significant life changes in past 6 months: ☐Move ☐ Death among family/friends ☐ Birth in family
☐ Relationship change ☐School change ☐Job Change ☐ Other

Please describe significant life changes: _____

_____

Medical History

Please list any current medications: Prescribing Clinician _____

_____ Dosage _____ Date Prescribed _____

_____ Dosage _____ Date Prescribed _____

_____ Dosage _____ Date Prescribed _____

_____ Dosage _____ Date Prescribed _____

Please list any allergies: _____

Please check any of the following that apply to the client's medical history.

☐ Asthma	☐ Genetic Disorder	☐ Immune Disorder	☐ Stroke
☐ Cancer	☐ Headaches	☐ Kidney Disease	☐ Tuberculosis
☐ Cystic Fibrosis	☐ Hearing Impairment	☐ Low Blood Pressure	☐ Thyroid Problems
☐ Cerebral Palsy	☐ Heart Condition	☐ Respiratory Issues	☐ Visual Impairment
☐ Diabetes	☐ Herpes	☐ Seizures	☐ Other _____
☐ Dizziness	☐ High Blood Pressure	☐ Shortness of Breath	
☐ Epilepsy	☐ High Cholesterol	☐ Stomach, Liver or Intestinal Problems	
☐ Fainting	☐ Hypoglycemia		

Please list any past hospitalizations, including reason, date, and hospital.

_____

_____

Has the client been psychiatrically hospitalized? ☐ Y ☐ N

_____ Dates: _____

_____ Dates: _____

Please list previous counseling, therapy, or psychiatric treatments.

Treatment Type	Dates of Treatment	Outcome
_____	_____	☐ Poor ☐ Fair ☐Good ☐ Excellent
_____	_____	☐ Poor ☐ Fair ☐Good ☐ Excellent
_____	_____	☐ Poor ☐ Fair ☐Good ☐ Excellent

Please describe any other significant surgeries, injuries, and illnesses.

_____

_____

Activities of Daily Living & Development History

Task	Unable	Total dependence	Mostly dependent	Requires assistance sometimes	Needs supervision	Uses devices	Independent
Bathing	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐
Mobility/transfer in bed	☐	☐	☐	☐	☐	☐	☐
Toilet Use	☐	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐	☐

Did the client have any issues with motor or speech development? ☐ Y ☐ N Please Describe: _____

_____

_____

When were these issues first identified? _____

Please list previous occupational, physical, speech, developmental, creative arts therapies or alternative therapies.

Treatment Type Dates of Treatment Outcome

_____ _____ ☐ Poor ☐ Fair ☐Good ☐ Excellent

_____ _____ ☐ Poor ☐ Fair ☐Good ☐ Excellent

_____ _____ ☐ Poor ☐ Fair ☐Good ☐ Excellent

Education History

Current School: _____ Grade: _____

At what age did the client start school? _____

Is the client in a mainstream classroom? ☐ Y ☐ N If not, what percentage is mainstreamed? _____

Has the client skipped or retained grades? ☐ Y ☐ N Which? _____

How are the client's grades? ☐ Poor ☐ Below Average ☐ Average ☐ Above Average ☐ Excellent

Have there been identified academic or learning issues? _____

_____

Does the client use any special communication devices? _____

What are the client's strengths and weaknesses? _____

_____

_____

Social History

Please describe how the client engages socially?

Parents

☐ Appropriate ☐ Confident ☐ Pleasant ☐ Loving ☐ Defiant ☐ Oppositional ☐ Passive ☐ Inattentive

☐ Avoidant ☐ Ambivalent ☐ Overly attached ☐ Reactive ☐ Manipulative ☐ Other _____

Family

☐ Appropriate ☐ Confident ☐ Pleasant ☐ Loving ☐ Defiant ☐ Oppositional ☐ Passive ☐ Inattentive

☐ Avoidant ☐ Ambivalent ☐ Overly attached ☐ Reactive ☐ Manipulative ☐ Other _____

Friends

☐ Appropriate ☐ Confident ☐ Pleasant ☐ Loving ☐ Defiant ☐ Oppositional ☐ Passive ☐ Inattentive

☐ Avoidant ☐ Ambivalent ☐ Overly attached ☐ Reactive ☐ Manipulative ☐ Other _____

Others

☐ Appropriate ☐ Confident ☐ Pleasant ☐ Loving ☐ Defiant ☐ Oppositional ☐ Passive ☐ Inattentive

☐ Avoidant ☐ Ambivalent ☐ Overly attached ☐ Reactive ☐ Manipulative ☐ Other _____

Does the client participate in after school activities? ☐ Y ☐ N Which? _____

_____

What hobbies does the client enjoy? _____

_____

Does the client have peers/friends? ☐ Y ☐ N Are they: ☐ Younger ☐ Older ☐ Same Age

Please describe the nature and frequency of the client's social interaction:

_____

_____

Has the client experienced bullying? ☐ Y ☐ N Did someone intervene? ☐ Y ☐ N

For Adolescents:

Is the client currently in a significant relationship? ☐ Y ☐ N If yes, with whom _____

Family Composition

Parent 1: _____

DOB _____/_____/_____ Deceased ☐ Y ☐ N

Gender: _____ Pronouns: _____

Marital Status _____

Education _____

Occupation _____

Health ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Religious Affiliation _____

Relationship to the Client

☐ Healthy ☐ Loving ☐ Strained ☐ Abusive

Present during Client's childhood ☐ Y ☐ N

Military ☐ Y ☐ N Division _____

Deployed ☐ Y ☐ N Length _____

Criminal Record ☐ Y ☐ N Incarcerated ☐ Y ☐ N

Parent 2: _____

DOB _____/_____/_____ Deceased ☐ Y ☐ N

Gender: _____ Pronouns: _____

Marital Status _____

Education _____

Occupation _____

Health ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Religious Affiliation _____

Relationship to the Client

☐ Healthy ☐ Loving ☐ Strained ☐ Abusive

Present during Client's Childhood ☐ Y ☐ N

Military ☐ Y ☐ N Division _____

Deployed ☐ Y ☐ N Length _____

Criminal Record ☐ Y ☐ N Incarcerated ☐ Y ☐ N

Siblings

1. _____Age _____Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
2. _____Age _____Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
3. _____Age _____ Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
4. _____Age _____Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
5. _____Age _____ Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive

Additional Family Information

Was the client adopted: ☐ Y ☐ N Age: _____ Type: ☐ Domestic ☐ International ☐ Kinship ☐ Foster

Has there been a divorce in the family? ☐ Y ☐ N Between who? _____

Is there a visitation schedule: ☐ Y ☐ N Describe _____

Custody Arrangement?: _____ Court Dictated ☐ Y ☐ N

Is the family currently involved in divorce or child custody court proceedings? ☐ Y ☐ N

Additional Parental Figures _____

Trauma History

Has the client witnessed or experienced a traumatic event? ☐ Y ☐ N

Please check the events that the client has experienced or witnessed.

☐ Natural Disaster	☐ Interpersonal control	☐ Assault/Robbery	☐ Other _____
☐ Serious Illness/Injury	☐ Physical Abuse	☐ Prejudice/Racism	
☐ Major Accident	☐ Sexual Abuse	☐ War	
☐ Parental Neglect	☐ Sexual Assault	☐ Community Violence	

What age did the client experience or witness this event? _____

Did the client receive therapy or counseling for this event? ☐ Y ☐ N Describe _____

_____

Substance Use History

Please mark the substances used by the client or close family members.

Substance	Frequency			Ages	Last Used	By Who?
☐ Alcohol	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Marijuana	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Cocaine	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Heroin	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Barbiturates	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Valium/Xanax	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ PCP	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ LSD/Mushrooms	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Inhalants	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Pain Medication	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Sleep Aid	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Stimulants	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Cigarettes	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Caffeine	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____
☐ Other _____	☐ Daily	☐ Monthly	☐ Socially	_____	_____	_____

Has the client or parent been disciplined at work, school or by the court for substance use? ☐ Y ☐ N

Has the client or parent participated in a substance abuse program? ☐ Y ☐ N Dates _____

Has the client or parent participated in a 12-step substance abuse program ? ☐ Y ☐ N Frequency _____

Relevant Cultural and Personal Information

Race/Ethnicity: ☐ White ☐ African American or Black ☐ Latinx ☐ Asian ☐ Middle Eastern/North African ☐ Pacific Islander ☐ American Indian/Native American ☐ Bicultural/Biracial

Does the client identify with a cultural, national, racial, religious, spiritual or social group? ☐ Y ☐N

Please describe their affiliation: _____

_____

Is there anything you would like us to know about the client's cultural identification? _____

_____

Does the client have any special needs or accommodations?

☐ Non-verbal or Adaptive Communication ☐ Limited motor function

☐ Use walker/wheelchair/cane ☐ Other _____

(which? _____)

Goals of Therapy

Type of therapy preference: ☐ Individual ☐ Family ☐ Behavioral ☐ Group ☐ Neurological ☐ Assessment

Past experiences with the creative arts (art, music, drama, dance, other)? _____

_____

Please indicate the goals you have for the client's treatment at this time?

☐ Symptom Reduction
☐ Increased Coping Skills
☐ Increased Self Care
☐ Improved Social skills
☐ Improved Communication skills
☐ Improved Social Relationships
☐ Improved Romantic Relationships
☐ Improved Family Relationships
☐ Increased Physical Skills
☐ Increased Cognitive Skills
☐ Sensory Integration/Processing
☐ Processing Traumatic Events
☐ Decreased Substance Use/Triggers
☐ Increased Creative and Artistic Expression
☐ Increased Personal Insight
☐ Improved Quality of Life
☐ Complete Court Ordered Treatment

Please list any additional goals _____

_____

_____

_____

If available, we would appreciate access to copies of psychological evaluations, IEPs, school evaluations, hospital or therapy discharge plans or any other professional reports. We will be happy to make photocopies for you.

Form Completed by _____(Print Name)

Client Signature (over age 12)_____Date_____

Parent/Guardian Signature _____Date_____

Relationship to Client_____

Mental Status Exam – Completed by Intake Clinician

Attitude

☐ Cooperative	☐ Uncooperative	☐ Cautious	☐ Passive	☐ Dramatic
☐ Manipulative	☐ Angry	☐ Domineering	☐ Evasive	☐ Overly Compliant

Appearance	Age	Grooming	Orientation
☐ Well Nourished	☐ Appears Stated	☐ Neat	☐ Person
☐ Malnourished	☐ Appears Younger	☐ Unkempt	☐ Place
☐ Overweight	☐ Appears Older	☐ Bizarre	☐ Time
☐ Emaciated			

Behavior

☐ Relaxed	☐ Restless	☐ Agitated	☐ Unusual Gait
☐ Tremors	☐ Tics	☐ Slumping	☐ Rigid

Memory

☐ Intact	☐ Impaired Remote Memory	☐Impaired Recent Memory	☐ Impaired Immediate Recall

Mood/Affect

☐ Normal	☐ Labile	☐ Elated	☐ Sad	☐ Depressed
☐ Restricted	☐ Inappropriate	☐ Suspicious	☐ Laughing	☐ Frightened
☐ Flat	☐ Frustrated	☐ Anxious	☐ Fearful	☐ Anger

Speech

☐ Unremarkable	☐ Excessive	☐ Slow	☐ Incoherent
☐ Loud	☐ Soft	☐ Stammering	

Insight

☐ Good	☐ Fair	☐ No Insight	☐ Denial

Thought Process

☐ No Abnormalities	☐ Word Salad	☐ Circumstantiality	☐ Perseveration
☐ Tangentiality	☐ Echolalia	☐ Difficulty Concentrating	☐ Incoherent
☐ Flight of Ideas	☐ Loose Associations		☐ Neologism

Ideation

☐ Suicidal ☐ Thoughts ☐ Plan ☐ Intent ☐ Past Description: _____

☐ Homicidal ☐ Thoughts ☐ Plan ☐ Intent ☐Past Description: _____

☐ Self Harm ☐ Thoughts ☐ Plan ☐ Intent ☐ Past Description: _____

Hallucination/Delusions

☐ None	☐ Visual	☐ Olfactory	☐ Persecution	☐ Somatic
☐ Auditory	☐ Tactile	☐ Influence	☐ Grandeur	☐ Reference

Judgment

☐ Intact ☐ Impaired

_____

Intake Clinician's Signature Date