Child Intake Form

Please provide the following information below needed for our records. All information will be held confidential in your client file. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session or email a copy prior to your appointment.

Name of person completing this form:
____ Your relationship to the child:
____ Home Phone: _____________________
okay to leave a voicemail: ___ yes ___ no
Work Phone: _______________________ okay to leave a voicemail: ___ yes ___ no Email:
____________________________________ okay to email a message: ___ yes ___ no

Name of other parent/legal guardian:
____ Home Phone:
_____________________ okay to leave a voicemail: ___ yes ___ no
Work Phone: _______________________ okay to leave a voicemail: ___ yes ___ no Email:
____________________________________ okay to email a message: ___ yes ___ no

Client Information:

Name: ____ Age:
__________ Birthdate (dd/mm/yyyy) _____________ Gender: ___ M ___ F (Other: _________)
Address: ____ City:
______________________________ State: _______ Zip Code: _____________ Emergency
Contact: _______________________ Phone: ________________

Academic Information:

Name of Child's school: ____ Grade: _______________

How did you find out about us? _______________________
Referred by (if any): ________________________________

Has your child previously received any type of mental health services, such as counseling or psychiatric services?
___ yes ___ no (If yes, please list provider, dates, focus of the treatment, and reason treatment was terminated)
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Medical History:

Please list current and past prescription *psychiatric medication* that your child is taking or has taken, including dose and frequency:
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Please list current non-psychiatric prescriptions/medications (including other the counter and

herbal supplements)

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Did your child experience any developmental delays?

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Name of family doctor/Pediatrician:
____

Child Intake Form

Phone: ______________________________ **Last physical exam/check-up:** __________________________

Results of the exam/check-up:

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Family History

What is the child's ethnicity and/or cultural heritage?

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Please list any medical (both physical and mental health – ***such as schizophrenia, bipolar disorder, major depression*****) conditions that exist within your child's family, as well as the family member with the condition:**

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Is there a history of drug/alcohol abuse and addiction within the family? If so, please describe:

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Is there any history of suicide within the family? If so, please list:

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Please list any siblings of your child:

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Social & Emotional

What is the problem that is bringing your child to therapy?

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When did this problem first begin? Was anything significant going on in your child's life at the time?

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On a scale of 1-10, how would you rate your child's current level of distress?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

How much does the distress affect your child's school performance?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)
Current habits:

Eating:
____
Sleeping:
____ Drinking
(alcohol): ____ Drug
use: ____
Caffeine use:
____ Exercise:
____ TV use:
____ Video
game use: ____
Internet use:
____
Cell phone use: ____

What hobbies or after school activities does your child participate in?

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What are your child's positive qualities and skills?

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What are your goals for your child's therapy?

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Any additional information you would like me to know?

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I have received and understand the office policies, informed consent, confidentiality, no secrets policy (couples and families only), text/email agreement, and HIPAA regulations in a verbal and written format:

X____ date ______________