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Child/Adolescent Intake Form

Child's Name:_____ **Child's Age:**_____

Guardian's Name (1):_____ Relationship to child_____
DOB:_____ Gender:_____
Home Number:_____ Cell Number:_____
Work Number_____ Permission to leave Message? _____ Where?_____
Home Address: _____
Occupation:_____ Employer:_____

(if applicable)
Guardian's Name (2):_____ Relationship to child_____
DOB:_____ Gender:_____
Home Number:_____ Cell Number:_____
Work Number_____ Permission to leave Message? _____ Where?_____
Home Address: _____
Occupation:_____ Employer:_____

Guardianship:
Who has legal guardianship of the child seeking counseling?_____
(If different than biological parent, a copy of the order granting guardianship must be provided prior to the first session. I acknowledge that both natural parents, even though separated/divorced, may have a right to obtain from the provider named below information regarding the nature and course of treatment of the child(ren).)

Primary Family Members:

Name	Age	Relationship to child seeking counseling

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Name	Age	Relationship to child seeking counseling

School Information:

Grade:_____ Name of School:_____

School address:_____Phone number:_____

Who is your child's primary teacher?_____

Has your child experienced any difficulties in school? Yes_____No_____

If yes, please describe:_____

Medical/Mental Health History:

Has your child previously received mental health services? Yes_____ No_____

If yes, indicate name of professional and dates of service:_____

_____

When was your child's last medical examination and what was the reason for the examination?

_____

Does your child drink alcohol or use recreational drugs (if you know)? Yes_____ No_____ If yes, please describe the nature and frequency of use:_____

Please list any mediations that are currently prescribed to your child and the reasons for taking such medication:

Medication Name	Take For	Prescribed By
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child have, or have they ever had, any medical conditions I should be aware of? Yes____

No_____ If yes, please describe:_____

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Were there any significant difficulties during pregnancy/childbirth? Yes _____No_____ If yes, please describe:_____

_____

Please circle any of the following that pertain to your child:

Nervousness	Depression	Fears
Shyness	Intrusive Thoughts	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness
Sleep	Stress	Work/School
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Decreased Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Nightmares	Appetite	Health Problems
Stomach/Bowel Trouble	Self-harm (cutting, etc.)	Separation Anxiety
Sudden Weight Gain/Loss	Change in sleeping patterns	Allergies
Aggression	Bed Wetting/Soiling	Truancy
Other:		

Please list any extracurricular activities/sports that your child participates in:

_____

_____

What are the primary issues/reasons for seeking counseling at this time?

_____

_____

How long have these issues been affecting your child?

_____

_____

Where are the problems observed most (home,school, work, etc…)?

_____

_____

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What do you hope your child will accomplish in counseling?

_____

_____

What does your child hope to accomplish in counseling (if applicable)?

_____

_____

Is there anything else you want me to know at this time?

_____

_____

Guardian Signature: _____ *Date:* _____

Guardian Signature: _____ *Date:* _____