CHILD INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Client Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if client is under 18 years):

____
(Last) (First) (Middle Initial)

Please answer the following questions related to the child client:

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: ____ May we email you regarding billing and/or scheduling information? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication so clinical information should not be emailed.*

Referred by (if any): ____

Has the child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _______________________________________

Is the child currently taking any prescription medication(s)?
□ Yes
□ No

Please list: ____

Has the child ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: ____

____

It is considered best practice in the mental health field and with insurance providers for me to coordinate care with your primary medical provider. May I have your permission to coordinate care with your child's medical provider?
□ Yes
□ No

If yes, please list your primary care physician's name and contact information_______________

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child's current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems your child is currently experiencing:

____

2. How would you rate your child's current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems your child is currently experiencing:

____

3. How many times per week does your child generally exercise? ___________

What types of exercise do they participate in? ____________________________________

4. Please list any difficulties your child experiences with their appetite or eating patterns

____

5. Is your child currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? ________________________

6. Is your child currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did they begin experiencing this? ___________________________

7. Is your child currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe ___________________________

8. Do you have knowledge of your child engaging in alcohol use or recreational drug use?
□ No □ Yes

Please explain____

10. Is your child currently in a romantic relationship? □ No □ Yes

If yes, for how long? __________________

On a scale of 1-10, how would you rate their relationship? __________

11. What significant life changes or stressful events has your child experienced?

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to the child in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Is your child regularly attending school? □ No □ Yes

If yes, what school?
____

Does your child enjoy school? If not, what do they most complain about?

____

____

How does your child get along with others at school? ______________________________

____

How does your child's teacher describe them? __________________________________

____

2. Is your child spiritual or religious? ▫ No ▫ Yes

If yes, describe your faith or belief:

____

3. Does your child have any specific relationship challenges? ______________________

____

4. What do you consider to be some of your child's strengths?

____

____

____

5. What do you consider to be some of your child's weaknesses?

____

____

____

6. What would you like your child to accomplish out of their time in therapy?

____

____

____

** If your child is 12 or older, please have them take the time to fill out the applicable questions on the regular Intake Form starting with General Health and Mental Health Information so that I can hear their perspective on these questions as well.