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.

Name of Child:
_____
(First) (Last)

Names of parents/guardians:

_____
(First) (Last)

_____
(First) (Last)

Child's 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? Yes No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):
_____

Your child's school: _____ Grade: _____

Why are you seeking services for your child?

_____

_____

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

Is your child currently taking any prescription medication?
Yes
No

Please list:
_____

_____
_

Has your child ever been prescribed psychiatric medication?
Yes
No

Please list and provide dates:
_____

_____
_

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:

_____

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:

_____

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

_____
_

5. What significant life changes or stressful events has your child has experienced recently:

_____
_

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 your 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	

DEVELOPMENTAL INFORMATION:

1. Did you experience any complications in pregnancy or delivery? No Yes

If yes, please give me a little more information:

_____

2. Has your child experienced any developmental delays (speech, walking, learning, etc.)?
No Yes

If yes, please give me a little more information:

_____

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

_____

_____

_____

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

_____

_____

_____

5. What are some goals you would like me to help your child achieve?

_____

_____