Intake Form

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

Child information

Name:_____DOB_____

Address:)_____

Phone #:_____

Email:_____

Parents/guardian information:

Name:_____DOB_____

Address:_____

Phone #:_____

Email:_____

Occupation: _____Place of employment_____

Marital Status_____

Name:_____DOB_____

Address:_____

Phone #: (H)_____(W)_____Can message be left at both numbers?

Email:_____

Occupation: _____Place of employment_____

Marital Status:_____

How did you hear of my services?_____

Child's Legal Status:

Legal Guardian (s)

___ Parents, no custody arrangements
___ Joint custody
___ Sole Custody Name: _____
___ Ward of State
Caseworkers name: _____Number:_____

Child's School Information:

Name of school:_____

Address:_____

Contact persons if applicable:_____

Special Education? _____ On IEP?_____

Medical History:

Child's Physician name:_____ Phone: _____

Present medical conditions and/or symptoms:_____

Medications currently taking:_____

Purpose of medications: _____

History of injury or illness: _____

Has your child been diagnosed with a learning disability? _____

Are there any religious, spiritual, or cultural beliefs that are important for me to be aware of?

_____

_____

Has anyone in your family experiences the following?

___ Depression	___Mood Swings	___Sexual Abuse
___Imprisonment	___Schizophrenia	___Alcohol Abuse
___Emotional Illness	___Suicide or attempts	___Drug Abuse
___Anxiety	___Child Abuse	___Physical Abuse
		___Other

Please describe further:

_____

_____

_____

Symptom checklist: please check items your child is experiencing or recently has experienced:

___Mood Swings	___Physical violence	___Hopeless thinking
___Too Little Sleep	___Too much sleep	___Unsure of reality
___Wish to Die	___Angry feelings	___Lack of energy
___Guilty feelings	___Confusion	___Excess energy
___Unusual experiences	___Low self esteem	___Suicide attempts
___Drinking problems	___Fears/nightmares	___Panic Attacks
___Drug problems	___School difficulties	___Stomach aches
___Unsure of identity	___Memory problems	___Vomiting
___ bed wetting	___Slowed thinking	___headaches
___ fluctuation in weight	___ day time accidents	___other

Describe: _____

Has your child been diagnosed with a mental health diagnosis? If so please explain.

_____

_____

Does your child take any medication for mental health?_____

Briefly describe why you are seeking counseling for your child at this time

_____

_____

_____

_____

_____

_____

Has your child been to counseling before?_____

If so, would you like me to have past records?_____

Name/number of past counselor (s)

_____

Is there anything else you feel that is important for me to know?

_____

_____

_____

Thank you for your time & honesty with this paperwork.